Who Speaks For Children?

The Report of the Study Commission on North Carolina's Emotionally Disturbed Children

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Raleigh, North Carolina
1971

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We hear a lot these days about resources—soil, water, air, forests, minerals, and the like—and we are constantly reminded of how valuable these resources are.

In recognizing and appreciating the value of these resources, we must never forget that people, productive citizens, represent the greatest assets, or resources, of all. And it is our children and our young people who represent our greatest resource potential.

—The Honorable Robert W. Scott
Governor of North Carolina
September 29, 1970

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WHO SPEAKS FOR CHILDREN?

The Report of the Study Commission on North Carolina's Emotionally Disturbed Children

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Published 1971 by
The Study Commission on North Carolina's
Emotionally Disturbed Children
Raleigh, Wake County, North Carolina
Library of Congress Number 72-633876

Printed By
North Carolina State University Print Shop
Raleigh, North Carolina

Printed in the United States of America

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Foreword

The Study Commission on North Carolina's Emotionally Disturbed Children was created in 1969 by the North Carolina General Assembly through Joint Resolution 629 with the mandate to "study in-depth the situation of the emotionally disturbed child and the mental health needs of all children in the State." It was charged to study and report measures for prevention, educational intervention, and treatment.

The time to do better by our children had arrived. The wish to do so had been there for a long time. But wishes have to be backed up by convictions that lead to action, understanding that leads to working through of low priorities for children, and confrontation of what we know and what we don't know. Citizens and professionals across the State have worked long and hard on bringing these issues to the General Assembly and following through with Study Commission Task Force reports. Although it is not possible to acknowledge all the many groups and individuals who participated in this cooperative effort, recognition should go to the Junior Leagues of North Carolina, the North Carolina Council of Child Psychiatry, and our editors who have brought a remarkable synthesis out of parallel and overlapping studies. Commission members provided a dependable stability throughout the study.

The Study Commission held its organizational meeting on February 6, 1970. Twelve major areas of Task Force study were set up: Child Advocacy, Joint Commission Report, Public Schools, Health Professions, Social Services, Juvenile Courts and Corrections, Mental Health Centers, Private Practice, Residential Treatment Centers, Regional Mental Health Centers, Training of Professional Personnel, and Research. Some 235 citizens were involved in the work of these Task Forces which included questionnaires, interviews, and public hearings. Position papers were received from a number of agencies and organizations in the State. State agency heads and members of their staffs met regularly with the Commission. There were twelve formal meetings of the Commission, thirty working sessions of Task Force chairmen, and countless individual Task Force forays. Valuable visits and docu-

ments from members of the Joint Commission on Mental Health, the American Psychiatric Association, the American Academy of Child Psychiatry, the American Association of Psychiatric Services for Children, the National Association of Mental Health, and the Group for Advancement of Psychiatry were obtained. Although the Study Commission did study and document a wide diversity of issues, there were many left untouched and much work remains to be done.

The summary report of the Study Commission was presented to Governor Scott and members of the General Assembly on December 8, 1970, at the Memorial Auditorium in Raleigh. Approximately 2,900 interested citizens from across the State were present. On January 14, 1971, in his State of the State Message to the General Assembly, Governor Scott said: "There are several agencies of State Government that are heavily involved with the well-being of our children. All of them are genuinely concerned and many fine programs exist. * There is, however, much fragmentation in services to children and youth. There is no one agency that can be considered as the spokesman for all phases of child development or aspects of the many problems of children. * For the past several months, a commission of legislators and citizens have been examining this problem. A report with specific recommendations calls for the establishment of a Governor's Advocacy Commission on Children and Youth. * I recommend the establishment of such a commission. It should take as its mandate the security and rights of all children and youth in our State. The commission would function as an advocate and not be responsible for providing services directly. * I commend the Commission's report to you and urge you to consider its recommendations."

It is with this same spirit that the Study Commission presents the full printed report of its findings. Citizens who are interested in a summary may refer to *Who Speaks For Children?*, published December, 1970, by the Study Commission. Other citizens or special interest groups may wish to look further into data, reports, and studies filed with the North Carolina Department of Archives in Raleigh. For the readers of this volume, the Study Commission hopes that the basic issues will be identified, and that its major recommendations will receive positive action from North Carolinians who care.

John A Fowler MD

John A. Fowler, M.D., *Chairman*

Summary of Recommendations

The Major Recommendation: A Governor's Child Advocacy Commission. North Carolina should establish a Governor's Advocacy Commission on Children and Youth by legislative action. The Advocacy Commission would plan, facilitate, and coordinate services and would serve as an advocate in the interest of children, youth, and their families. It should take as its mandate the security and rights of all children and youth in North Carolina. The Commission would not be responsible for providing services directly, as this function would be incompatible with its role as advocate.

It is recommended that the Governor's Advocacy Commission be composed of nineteen persons, including citizens, legislators, and administrators of child-serving agencies. It should encourage the formation of regional and local advocacy groups.

Recommendations on Programs and Services. North Carolina needs a vision of child care which provides for the total child. This requires a comprehensive plan of child care which coordinates the services of all agencies involved in the care of children.

The Study Commission found that no single community or county in North Carolina offers what can be considered comprehensive care to its children. We must know about the children whom we are serving, the services we are now providing, and the services we are not providing.

We need a plan for child care in which programs are designed to fit children, rather than agencies or professionals. We must do less "crisis" work and work harder to develop preventive programs. We must take stronger measures to help troubled children in their regular school and community environments. Where this is not possible, we must have adequate treatment centers. We must give more attention to adequate infant care, and we must establish program standards for the care of our young in day care and preschool programs. We must give more attention to helping teen-agers cope with

problems, such as drugs and early pregnancy. We must improve the methods by which we assist the young lawbreaker back into society.

The Study Commission recommends that all State agencies concerned with children and children's services should be encouraged to share budgets through inter-agency planning. We must continue to attack the problem of how to help those who are unable to pay, unaware of where to go for help, or unaware that their child needs help.

Recommendations on Manpower and Training. A comprehensive plan for services requires new concepts of training those who work with children. Few children's problems fit into the disciplinary lines of highly specialized professions. We need a new concept of training which recognizes interdisciplinary training. The person entering nursing, education, social work, psychiatry, or other disciplines must be familiar with more aspects of a child's life than those covered in his specialty.

Interdisciplinary training should come during a person's regular training for his specific work. Training programs should provide an early chance for work with children and adults in a variety of settings that extend beyond the boundaries of one profession.

A broad range of professionals are concerned with the happiness and well-being of children — educators, health personnel, ministers, group workers, juvenile law and court personnel, social workers, psychologists, and psychiatrists. At present, not enough of these people are being trained to handle the problems of children.

Training for work with children is not available in all regions of the State. Institutions and agencies across North Carolina—universities, community colleges, hospitals, technical schools—should cooperate to provide special courses to help develop skills for working with children and families.

Recommendations on Research and Evaluation. We must know more about current efforts to help children—what is strong in our programs, what is weak. We need to know how to improve existing programs and what new ones are needed. To get this job done requires looking at significant questions, having trained researchers, and funding research efforts.

Today, child research in North Carolina is hindered by a shortage of trained personnel, lack of financial resources, lack of emphasis on conducting research and utilizing findings, and a lack of communication among individuals and agencies.

We need more research efforts to find out what occurs in child development between conception and age six, what kind of day care standards should be required, and what methods of early screening and evaluation will best detect physical and emotional difficulties. We need to know more about disadvantaged children and how traditional services and educational methods should be modified to help them. We need to know more about adolescents to help prevent the alienation that leads to drug abuse and juvenile delinquency. We need to develop more effective communication and counseling for this age group.

Chapter I.
Current Issues Related to the Commission's Study of Children

Our State says children are our most precious resource. In North Carolina we spend 70 cents out of every State tax dollar for education—three quarters of a billion dollars a year. We spend many millions more to make sure children are healthy, well-cared for. Children have been our first priority.

Yet there are thousands of troubled and sick children in North Carolina for whom no help exists. There are many children who do not have the opportunities they need, who are unhappy, uncared for. When these children come to school, many fail the first grade because of health, learning, or social problems. We see them among the 45 per cent of children who drop out of school before graduation. We see them in the courts and among the 1,700 new youngsters who are placed in juvenile correction centers each year. They are among the unmarried teen-age mothers who give birth to approximately 8 per cent of babies born each year in North Carolina.

Why, when we have committed so much of our resources, do we find so little has been done for children? Why do we find that so many of the children who need help the most have apparently received help the least?

The Need for Redefinition of Priorities. The question of priorities for work with children was one which members of the Study Commission and its task forces returned to again and again. In seeking answers, the Study Commission entered into a redefining of priorities. Some old values were reinforced, and some new directions may be indicated.

The question the Study Commission asked about children is asked by many groups and individuals today. It is behind the idea of accountability, whereby we no longer take for granted that merely funding a program or idea will make it work. Enlightened citizens are demanding that work with children be productive or that we should try something else.

The need for some changes is obvious. Most North Carolinians recognize this. A review of some facts presented later in this report presents clear evidence.

Where do we begin making things better for children? Begin by looking at the world of children, not just an individual child, not just the child who is ill.

How to Look at the World of the Child. We must ask ourselves: What makes the best environment for children—what services and relationships and opportunities are provided in this environment? We need to learn what we could have done to prevent a child's problems. We need to ask if we are doing the best we can to help the sick or handicapped or chronically ill child.

All of our young have certain needs as they learn how to cope with the problems of life. Traditionally, the adults in a family have helped the young learn to become adults. The process or interaction between the young and adults has involved both groups intimately and daily.

The family and the community share the responsibility of speaking for the needs of children—they are the traditional child advocates. Child advocacy means someone who takes the part of the child, who speaks up for him, stands with him, who protects his best interests, who can be counted upon to champion his cause. In a sense, a child advocate pleads the case of the child to other sectors of public and private interest.

When we speak of child advocates, are we speaking for all children? The Study Commission feels that the answer is yes. Each child needs an advocate, usually his parents, who look out for him in this way. All children need advocates, voices in communities, who represent children in community decision-making. Children are helpless in that their interests are not represented in voting, in decisions, in courts, except as adults speak for them.

When the Study Commission considered the condition of children and their dependency on adults, the Commission recognized that most adults say that they want to *do right* by children. Parents, teachers, community workers, child specialists lobby for special groups of children. Sometimes communities or states are aroused for particular children who suffer. Through feelings such as sympathy, guilt, or compassion, adults contribute funds to or vote for certain child causes.

The Individuality of the Child. The Study Commission considered it essential that citi-

zens begin to identify with the cause of children. Each child has an unique blend of abilities and disabilities. Many times these unique characteristics are not apparent until adults become puzzled about him. Outstanding champions of children have exhorted us to *look further* or to *listen to the patient*—that is, to see or perceive the inner child, often inscrutable by superficial observation. These looking and listening qualities on the part of adults help identify illnesses, health problems, concerns, and other invisible needs of children. Adults who look and listen to children communicate to a child that an adult cares. An adult who is a child advocate might adopt the statement of the 1971 White House Conference on Children and Youth: "To enhance and cherish the individuality and identity of each child through the recognition and encouragement of his or her own development, regardless of environmental conditions or circumstance of birth."

The Need for Child Advocates. Today, many stresses in our society make it difficult for the traditional advocates to be heard. No single agency in the community speaks for the total child. Efforts to help children are fragmented among agencies. There is little coordination. There is no plan for developing services to fill the gaps that exist in the care of the young.

Too often in speaking about a child, adults say "he'll grow out of it." But what about those who don't grow out of it, who develop into disabled or ineffective adults, who are much less than what they could have been? And of what does the *growing out of* consist —and who facilitates the growth?

A child's world is a small one. He cannot escape it. He is stuck in what we make of it for him. Much of his world seems mysterious, unreasonable, fanciful, of the moment.

Society has assumed the task of providing public education for the child, a degree of health care, and special help for the child with special problems. It has been taken for granted that, for the most part, the child will adapt—he'll learn to get along in his world. This sink or swim attitude seems very out of place. Today, the world of both children and adults is far from simple. It is a complex world in which *adaptability* has become a byword—partially because adapting to changes has been so difficult for many adults.

We must recognize that children are not made to fit into, to adapt to *any* environment. It is the other way around. We must recognize that children are truly individuals and that they have a dignity and wholeness which we risk destroying when they are given only packaged responses and environments. Neither is it to children's best interest to place on them the burdens of consequences of decisions which they are unable to make.

Looking at each child is not easy. It requires sensitivity, awareness, and patience; and, for many of the tasks this report will deal with, confidence and training.

Speaking for children, for their genuine needs, is the logical conclusion of our belief that children are the most precious resources. This report will discuss how we can assure that voices for our children will be heard. It will re-examine planning for child care, a way through which we speak for the needs of children. It will also look at the shortage of trained professionals who work with children and make some suggestions about the training of child health and education professionals that will enable us to better use resources available. This report will also point out the need for research, another means by which we speak for the future needs of children. It will recommend a new structure in society, called a Child Advocacy Commission, where a unified voice for children can be heard.

Some Factors Inhibiting Perceptions of Problems. Some considerations affecting the lives of children have been avoided because we have tried to fool ourselves into believing we were doing nearly everything we could for children—despite the fact it wasn't working for many.

Many adults will speak freely of "how hard they have worked," "how they have sacrificed" for their young. Some adults describe young people as unappreciative of the adult world. Some adults speak of childhood as the "happiest time" with no responsibilities.

Most of us reflect in our view of children our own childhood and the glimpses into childhood that we have when we rear our own children. Some of us can identify with the pain and uncertainties of being young. Others of us may not allow ourselves to recall those feelings again. Many of our past feelings of being powerless, unloved, ashamed, lonely, misunderstood are recalled if we truly identify with a child or children. This may be especially true with children who are very disturbed, very handicapped. Some adults will have nothing to do with such children; they want to isolate them from *normal* people, or want to give large funds to someone else to *do something with them.*

Experience shows that, as difficult as it is to accept a physical handicap in a child, it is harder for some people to accept emotional and psychological disabilities of children. Somehow the crippled mind and emotions seem so much more dangerous to us than a crippled limb. It is easier to think of a specific disability than a more pervasive, illusive illness. Scientific research into the problems of the physically and emotionally disabled is still in pioneer stages, but much more is known about origins and interrelationships than we seem able to apply in actions.

There are probably many other reasons for the dissonance about children as shown by adults, especially professional adults who work with children. Child workers are frequently viewed as selecting a less prestigious spot in the affairs of the world, incomparable to such functions as buying and selling or political statesmanship. In many ways, those who work with children may be seen by others as somewhat infantile to be interested in "child's play," in the affairs of children. To such adults, the real problems of the world could not possibly involve dependent children who have no hard sell in the market place.

Children have no money to spend, no vote to cast. They may easily be seen as consumers of adult money, time, effort, and services. There are feelings in adults which are anti-child in that the extended care of children seems to be needed, that higher taxes are needed, that choices of such programs as space, missiles, etc., are in juxtaposition to child care.

Professionals in child programs may exhibit anti-child behavior in not being willing to share services, to learn from each other, and to keep the child as the primary focus of their efforts. Professionals who claim to be interested in children may suffer from the kinds of rivalries, insecurities, competiveness which they experienced as children themselves.

The roots of these feelings about children may be difficult for us to recognize and illuminate with understanding. Yet the concept of child advocacy suggests not only speaking for the child, but an identification of adults who are free to speak for children. It raises the question of the psychological freedom of the adult and the receptivity of society.

The concept of child advocacy has as its goal a healthy child in a healthy society. It would include all children from birth to age 18—babies, toddlers, preschoolers, school age youngsters, teen-agers, dropouts, handicapped children, juvenile offenders, pregnant teen-agers, *all* children and youth. And the advocacy idea in the term *child advocacy* includes all adults who potentially could identify with commitment to healthy children in a healthy society.

The Changing Role of the Family. As envisioned by the Study Commission, the advocacy function becomes an important support for the family at a time in history when the role of the family is seriously threatened. The large, tight-knit family is gone for most people. Along with it, we seem to have lost the stability, security, and the care of the community as most of us remember it.

Today, the family is a smaller unit, it seems more vulnerable. Children receive more and more of their formative experiences outside of the immediate family. Families which are intact are subject to pressures and complexities which were previously unknown.

Few would disagree that it is imperative to strengthen the role of the home. It performs a function which seems irreplaceable by any other institution.

One way to strengthen the home is to strengthen the community and its relation to the family. It is not just a coincidence that at the same time the family has been weakened, community and neighborhood bonds have been loosened.

Child advocacy as proposed by the Study Commission would foster community services and utilize State leadership to insure the development of community programs and services. On a community level, this undertaking could be formalized as a local child advocacy council. On the State level, this responsibility could be formalized as a Governor's Advocacy Commission. The results of the work of State level and community level advocacy should revitalize a valuable characteristic of the true neighborhood—helpfulness. Through local advocacy councils, members of the community would stand with the child and family in times of need.

A mother seeking day care services for her child would find assistance from the neighborhood advocacy council in securing this kind of service.

Parents of a handicapped or sick child for whom no help or services were available would find the local advocacy council an ally in making their needs known.

Citizens and parents who wanted to secure new services or opportunities for their children would find the advocacy council a natural forum.

Parents and older citizens who wanted to help children would have in the advocacy council a place to begin finding means of involvement.

Excellent Programs With Which to Begin. Many communities and agencies throughout North Carolina are trying to provide more comprehensive care for children. These efforts are often sporadic and fragmentary. They usually serve particular needs of certain groups of children. Yet, they are indicative of the concern today that more be done for the total well-being of children. A few of these efforts provide for training personnel and for research studies. The results of such efforts will strengthen and contribute to the direct care provided for children.

These programs range from infant and child care to voluntarily staffed drug abuse clinics for teen-agers. Our efforts to create educational programs that speak to the whole child is another indication of the awareness today that a broad view of the child is needed.

Programs for the Very Young

In Greensboro, the Child Care Center operates a program in which preschoolers and their parents share experiences directed toward learning and building self-respect. Also, there is a project to train teen-age mothers how to care for their infants. This project is conducting infant research studies to assist other groups in developing programs.

In Morganton, Skyland Day Care Center, sponsored by an industry, provides care for toddlers whose mothers work for the indus-

trial plant. Mothers see their children in the plant nursery during the breaks in their day.

In Elkin, all children come to summer school before first grade, giving them and their teachers a chance to know each other. The school program then is adapted to each child's needs. Research data from this program will help other schools and communities help school beginners.

In Haywood County, eight major agencies cooperate to offer assistance to all high risk babies; to provide special health care to children under age five; to follow children after hospitalization. Children entering school are provided special screening. School personnel who participate in the school screening receive valuable training in understanding young children.

Programs for the School Age Child

In Raleigh, Project Enlightenment is providing assistance to young children and their teachers in nursery schools, child care centers, and kindergartens. Another program, Bridges-to-Hope, provides an individual child with a friend—like a big brother—who helps him as a special person.

In Pitt County, a resource teacher, especially trained, works with autistic children.

In Moore County, Project CARE offers a reorganized school environment for children, some of whom have trouble learning. Children help children, and parents participate in the program.

In Durham, the county and city schools provide a program in which child specialists come into the schools to work with the child, his teachers, and his parents. Wright School is strengthening community services across the State for children who come for re-education. These two programs provide training sites for a variety of child-helping professionals. For example, teachers, counselors, child specialists, nurses, psychologists, and child psychiatrists receive training in these sites.

Programs for Teen-Agers

In Winston-Salem, the Youth Services Bureau provides community-based programs for troubled youth, some of whom are returning to the community from State penal institutions.

In Chapel Hill, teen-agers are helping other teen-agers through Operation Switchboard, a drug abuse action group.

The Cooperative School in Durham helps adolescent pregnant girls who want help and continued schooling.

No Unified Commitment to Children and Youth. There is no unified commitment in North Carolina to youngsters. The Study Commission did not find a single community offering what could be considered even mediocre comprehensive care to all its children. Very few programs provide for the delivery of services, the training of personnel, and research and evaluation studies on the results of the programs.

What is meant by "comprehensive care"? It means that at each step of a child's life—the prenatal stage, as he is growing up, as he goes to school—there are continuous avenues for care. The child is given the opportunity for total development. There is a helping hand for the child who needs it.

Comprehensive care is a multi-agency

domain. But, it requires organization and coordination if the services of child agencies and specialists are available and able to help children when help is needed.

All children, from time to time, need help in resolving emotional conflicts if they are to develop full, happy lives. During infancy and preschool years, children are especially vulnerable to pressures as they try to learn to grow up.

The Study Commission found there is no real aid available to children in coping with emotional conflicts. What services we have are scattered and frequently unavailable to large segments of the child population. The services are also fragmented by haphazard and unsatisfactory communication between the various agencies involved.

The Study Commission found North Carolina doctors in agreement that needed services are not readily available throughout the State. Through a survey conducted by the Task Force on Private Practice, doctors reported considerable difficulty in getting many of the essential services, especially in eastern and western counties. Doctors in most communities reported services are simply not available or too expensive for the patient who needs counseling or special education help.

"Programs for prevention, educational intervention, and treatment are unevenly distributed, meager in quantity and quality, and poorly coordinated. Services are deficient in quality, if not quantity, for prenatal care, infant care, preschool care, and support of the public school classroom teacher." This was the situation found by the National Commission on Mental Health of Children. According to findings of the North Carolina Study Commission, similar problems exist in North Carolina.

We know we are not doing enough to meet these needs. The Study Commission found North Carolinians ready to do more. There is a growing mood in the State for change and improvement. It underlies the legislature's creation of the Study Commission.

Needs of All Children. There is a new public awareness of our responsibilities toward children to optimize children's health and opportunities for development. The Study Commission agrees with the National Commission's statement of beliefs for children.

Each child must be granted:

—the right to be wanted
—the right to satisfaction of basic needs
—the right to continuous loving care
—the right to acquire intellectual and emotional skills to achieve individual aspirations and to cope with demands of society
—the right to receive care and treatment through facilities appropriate to his needs and as close to his home community as possible.

Most child-care agencies are highly specialized. They treat only a certain segment of the child's world. This results in a kind of professional myopia which creates incidents like the following. In our State capital, a boy was turned away from classes for the retarded because he was partially deaf, from classes for the deaf because he had emotional problems, and from classes for the emotionally disturbed because of his intellectual limitations. In another instance, parents pled without success to more than fifty agencies to help their child.

Too many children, for whom referral agencies either do not exist or which lack resources to adequately treat the children

they were created to serve, live with problems which cripple or destroy their lives. We see the results of these unchecked problems every day. They erupt into school or social difficulties. Often they end up in the courts. Not only is this harmful to the child immediately affected, but often other children in the family become caught up in disruptive patterns of behavior.

At least 10 per cent of school age children need some help for emotional problems. Most of these children receive little or no treatment. Many of them have problems long before they enter the first grade. By the time these children enter school, they often bring with them a problem that is becoming ingrained in the child's character and creating additional maladjustments in other areas of the child's life.

Some method of detecting handicaps and maladjustments early in a child's life is badly needed in North Carolina. Few Developmental Evaluation Clinics and Pediatric Supervisory Clinics have personnel to work specifically with the mental health needs of infants and preschool children. In many areas of the State such personnel are not available. Many families with troubled children are unaware of their child's problems or the nature of the care offered by these clinics. This condition emphasizes the need to reach the family on the neighborhood level with help and parental training programs.

North Carolina is establishing a statewide public kindergarten system. This appears long overdue; most children in the United States have access to public kindergartens. It is tragic that there are five-year-olds who are unable to attend kindergarten because North Carolina has not had the funds or adequately trained personnel to offer *every* five-year-old kindergarten opportunities.

The Study Commission also found that few social service agencies in North Carolina have personnel to work specifically with children. Where such programs can be offered, they often overlap. The Department of Social Services provides psychological services for children in areas where the same services are offered by facilities of the Department of Mental Health.

Fragmentation of Services. The Study Commission found example after example of poor inter-agency planning, or no planning.

The child in trouble may be involved with several different agencies without any agency knowing of the involvement of the others. There is also the opposite effect when no agency takes adequate responsibility, as seen in the recent case of a ten-year-old who remained in a city jail for over a week.

Licensed foster homes are difficult to find in urban areas, often where they are needed most. Although youth organizations are well organized in rural areas, they are not so well organized in urban centers. Juvenile detention homes appear to be completely missing in many sections of the State, particularly in the rural areas.

The lack of health care personnel in North Carolina, as well as the rest of the nation, is a serious problem. Particularly in rural areas, the absence of such basic health services as general medical care constitutes a grave crisis for many North Carolinians. There are other North Carolina State commissions working with this problem. This report will make its own recommendations regarding it in a section on the training of personnel.

Another situation reported to the Study Commission is that programs for child services in North Carolina are heavily centralized. A large proportion of the professional personnel and service facilities are concentrated within a twenty-mile radius of the Raleigh-Durham Airport. This area has 21 out of the State's 30 child psychiatrists. In order to balance out the needs of different areas of the State and to establish training programs in those areas now poorly served, creative planning is needed regarding the utilization of available skills.

In most communities where there are services, however, these services frequently do not go beyond diagnostic procedures. There is a lack of psychiatric treatment within local mental health clinics and little consistent follow-up. We simply do not have anywhere to refer many of the problems we diagnose. More preventive, treatment, and follow-up services should be established.

Several Task Forces of the Study Commission noticed this. A heavy emphasis in our State is placed on psychological tests, not only for the exceptional child, but for the average child. We fail, however, to follow up and do much about the problems and weaknesses or talents and strengths the tests reveal.

Labeling the Child But No Follow Up of the Needs. Often we do no more than diagnose a child as failing in school due to lack of interest or poor concentration. We fail to see beyond the label and to become genuinely aware that the child is sick, or that his world, family, or environment is so unstable, or in such turmoil, that he may be fighting for survival. The Task Force on Schools pointed out that a variety of educational labels exist for the child with emotional problems. Another set of labels for such children is used by medical personnel—and another, by legal authorities. There seems to be no uniform understanding of the child, and no common description of his needs and problems.

We seem to value the label and yet we dismiss the child. He often becomes someone else's concern. There is a tendency to use diagnosis as an excuse to eject a child from normal society. Children should not be labeled as retarded or emotionally disturbed in order to set them apart from other children in special classes or in a special center. It is important that children with these problems remain participants in society and to learn how to take responsibilities in society. Authorities say that many children are taken away and placed in institutions when with small effort they could remain in their communities.

If a child in an institution is mistreated, a complaint is sometimes filed with the Governor. The practice has been for the Governor's office to send the complaint to the State agency involved, which sends the letter down the administrative ladder. The letter ends up in the hands of the person against whom the complaint has been made, and often this person is unable or unwilling to make a change in his procedures.

Consideration of this summary of our situation makes its obvious there is a job for child advocacy in North Carolina.

1964
ANNISTON ALA

Chapter II.

The Healthy Child —And The Child Who Is Not

Adults who live with children usually know when a child is feeling good about himself and his world. Sometimes a child who feels good about himself is said to have a sense of well-being. In technical language, professionals may describe such a child in various ways — such as having a positive self-concept, being well-adjusted, as having emotional stability, or exhibiting a well-developed ego.

Parents and professionals may use different ways of describing their impressions of a child. Despite the differences in descriptive language, most adults recognize the happy boy or girl. A position paper submitted to the Study Commission by the North Carolina Council of Child Psychiatry describes the healthy child as "one who actively, flexibly, rationally, and age appropriately masters his environment most of the time, exhibits the capacity for love, work, and play, and enjoys a certain sense of mental well-being."

As presented in Chapter I, the Study Commission recognized that various needs of children have to be met in order to insure good mental health. Such needs include, for example, that a child be wanted, to have care, to become skillful in the developing of self, to receive the individual help he needs. Such needs have been described by the National Commission on Mental Health of Children and have found substantial support of national leaders.

Interest in the Healthy Child. Testimony to the Study Commission has noted that for the past quarter century the *healthy model* has been the object of study for child specialists, although they may be chiefly involved with ill or sick children. The goal of work with sick children has been to help them become as healthy as possible and to develop ways of sustaining that health.

From what we know of the new born baby, he responds to a person who cares for him, one he can learn to love and to depend upon. He responds to an environment that is safe, stimulating, and trustworthy. He develops an enormous mastery of this environment during his first few years. He learns to crawl and walk and talk and to have relationships with other human beings. He begins to learn about social standards and expectations of others. He develops some independence of mobility and self-direction. He learns to take care of some personal needs and develops some social skills and feeling for others. He needs care and protection and love from other human beings.

By the time he is able to go to nursery school or kindergarten, he has developed some habits of attending, of knowing some rights from wrongs, and of feeling that the world is a safe place. He learns that he can go out into strange places and come back home to find loved ones. By the time he is six, a child has developed, in a phenomenal way, a sense of self and others.

When he steps away from home and goes to school, he enters an environment of more formal learning. The classroom offers a continuation of the kind of learning he has been doing, but with a different set of tasks and a different teacher (not his mothering person). He learns to share this person with many more children, not his brothers and sisters at home, but 25 to 30 "brothers and sisters" at school. He is developing a concept of being a boy, not a girl or vice versa, and utilizes opportunities to develop his identification.

During the elementary years a child is asked to undertake many cognitive tasks, to learn facts, skills, and attitudes, to get along with others, to take responsibility. He identifies with his sex group and develops friends of his own. He is more able to leave home for most of the day.

With the advent of adolescence, a child en-

ters a long stage of pre-adulthood. Too long, some adolescents feel. He may, as a young teen-ager, have great energy and many interests. He may take on, with idealism, causes and services to others. He is able to fall in love, fall out of love, and fall in love again. He develops ideas of the work of the world, what he wants to do, and he begins to prepare for the work he chooses. Within a few years he is able to drive a car, vote, marry. He may hold a job, serve in the armed forces, move away from home and start a home of his own.

During these years from infancy through adolescence, a child's basic personality and character is being formed. This seems to be the time he forms attitudes towards trust, towards security, towards adventures and curiosity, towards loving others and being loved. Much of the child's development is especially controlled by those who have responsibility for him. These persons mediate the outside world and its workings to him. Many of the events of his world may be—like life—up and down, sad and happy, routine and stimulating. He learns to regard the world largely in the way others interpret it and in the way he develops some control over his life.

Events in his family, social and other types of crises affect him. With help he develops, in some measure, strength, independence, confidence, and trust.

The Role of Conflict in Child Growth. It appears that conflict plays an important part in the growth and development of children. The way a child learns to handle his feelings, to cope with relationships, social expectations, and authority has much to do with developing the maturity needed for adulthood. In the development of healthy children, it is recognized that the child is very much in the state of becoming. The best situations for children are ones that help them achieve their potentials.

All children have emotional conflicts in living and growing up. Without dealing with conflicts, no growth and development takes place. Normality is the ability to cope *most* of the time satisfactorily. To cope satisfactorily most of the time is to be happy most of the time. Infants, children, and youth learn this routinely from parents, other children, and classroom teachers.

Infants and preschool children are especially vulnerable to interference in the development of coping skills. When a child feels that he cannot cope with problems, he is unhappy most of the time. He develops disturbing behavior. This may lead to not learning in school. It can show in complaints, such as headache, stomachache, and being nervous, tired, and uneasy. It can show in delinquent acts, in excessive drug use, in violence against himself and others.

Inability to cope with emotional conflict is

present in all children from time to time. At times stress is more apparent in children even though the impact of stress varies according to the child. Mothers know that toddlers cry more when they are left between the ages of one and two. Fathers know that their six-year-old daughters talk of "marrying Daddy" when they grow up. Teachers know that an elementary age boy wants to be on the team, to have a buddy, and to be considered manly. Parents know that a teenager is unhappy if she wants to go to a party, but no one invited her. Sometimes children feel they grow too fast or not fast enough; sometimes they think something is wrong with their heads or their bodies. There are events, many beyond the control of adults, that are difficult for any child. Some examples include going to the hospital, the loss of a loved one, the arrival of a new baby, the lack of an adult to believe in, the acceptance of a handicap.

Children differ in their abilities to respond to these typical or unusual situations. When emotional growth does not develop as appropriate for his age and sex, the child has been labeled by a variety of descriptions. Some typical labels include emotionally disturbed, emotionally ill, mentally ill, emotionally handicapped, mentally handicapped, emotionally impaired, etc. Along with this constellation of descriptions, there are associated labels such as neurologically impaired (emphasizing nervous system disorders), autistic (implying communication and responsiveness disorders), mentally retarded (emphasizing cognitive deficiencies), learning disabled (emphasizing receptive, expressive, and perceptive disorders). It is difficult to identify a description of child disturbance that has a universal definition. As pointed out in the North Carolina Medical Society position paper to the Study Commission, "no universally accepted diagnostic criterion" exists.

A description formulated by a Menninger Foundation staff member of this type of child may be as acceptable as any. An emotionally disturbed child, according to Lois Murphy, is one "whose emotional responses to the stresses of his life are disrupting to his growth and his relationships with his environment."

The General Assembly Resolution creating the Study Commission estimated that North Carolina had approximately 193,000 emotionally disturbed children. The National Joint Commission reported 1,400,000 youngsters 18 years or younger in the United States who were in need of immediate psychiatric care.

Identification of Emotional Disturbance in Children. In North Carolina, how is the upset child identified, the one who is disturbed sufficiently that his growth is interrupted? The Study Commission undertook to collect data from official boards, agencies, and organizations with statewide responsibilities for such children. In a sense, each set of data from an agency represents one view of children according to the policy and mandate of the agency. It is apparent that there is no uniform collection of facts about existing conditions or existing services for children in the State at this time.

The following data reported to the Study Commission seemed relevant to the identification of troubled children. Information is included from these following sources in this order: Mental Health Clinics, Public Health Pediatric Clinics, Developmental Evaluation Clinics, Outpatient Hospital Clinics, Private Practitioners, Social Service Departments, Inter-agency Day Care Centers, Residential

Treatment, North Carolina Society for Autistic Children, and Juvenile Correction System.

The Study Commission attempted to gather information about the kinds of children who were seen by these services. The information which was collected is partially complete. Of the surveys conducted by Task Forces of the Study Commission, no returns were 100 per cent complete. No common or accepted terminology exists for questions about children. Each agency interprets questions according to its own standards and points of view. This lack of standardization of basic information about children seemed to be one of the striking findings of the Commission work and has led to several of its recommendations about data collection, central information services, etc.

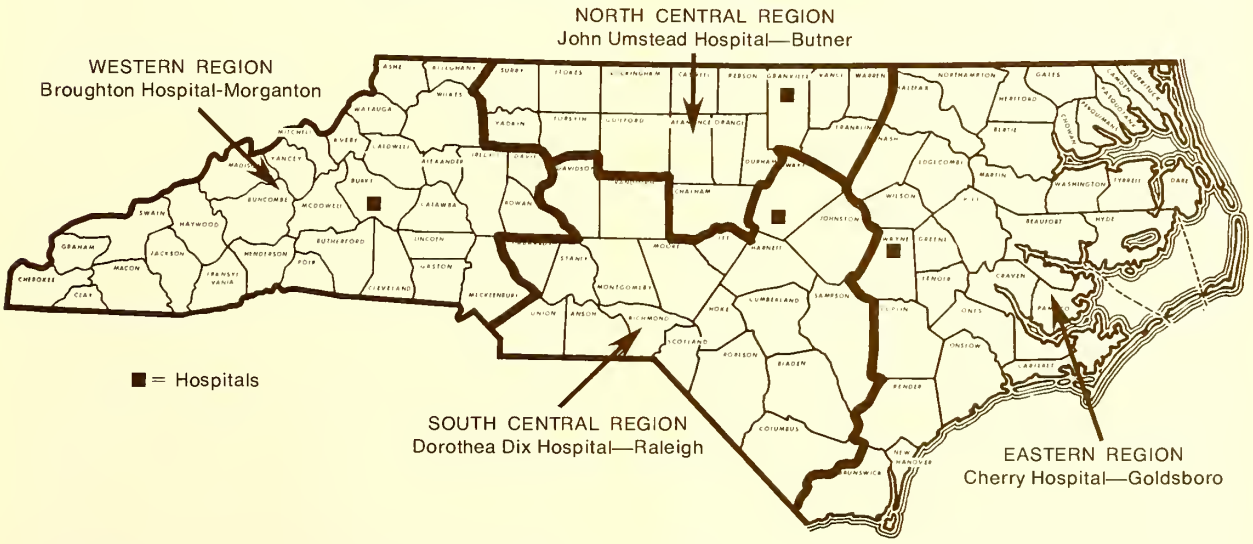
The Child Population of the State. The Study Commission accepted a definition of children as including the population of children and youth under age 18. (By some Federal standards the word *children* describes the child until he is 21.) Most of the North Carolina agencies serving children extend services to age 18. The National Commission on Mental Health of Children defined the term *child* to include to age 18.

In order to accurately estimate the North Carolina population of children, the Task Force on Mental Health Clinics followed this procedure. Utilizing the 1968-69 **Estimates of the Population of North Carolina Counties,** a table was compiled showing a total of 1,836,304 child population. As can be seen by this table in an appendix, approximately 36 per cent of the population of the 100 counties of North Carolina is under age 18. The ratio of percentage of children to total population within counties extends from approximately 22 per cent in Madison County to 46 per cent in Jones County. As to the four regions utilized by the State Board of Mental Health, the ratio of percentage of children to population ranges from high to low in this order: South Central Region, Eastern Region, North Central Region, Western Region. By density of child population, counting all children, the rank order by regions is as follows: Western Region, South Central Region, Eastern Region, North Central Region.

TABLE 1. POPULATION BY REGIONS

Regions	1968-69 Total Population	Under 18	Pct. Under 18
South Central Region	1,309,529	485,197	44.7
Eastern Region	1,094,350	424,825	38.8
North Central Region	1,143,467	393,827	34.4
Western Region	1,572,279	532,455	33.9

MENTAL HEALTH ADMISSION REGIONS



Provisions for Child Care and Treatment. Babies and young children of North Carolina come in contact with a variety of child-care personnel in formal and informal ways. In addition to parent or foster parent care, babies and young children are cared for and supervised by private doctors, public health pediatric clinics, public diagnostic evaluation clinics, mental health centers, child guidance clinics, day care centers, hospital clinics, other specialty clinics, and public and private residential institutions.

Public Health Pediatric Clinics. Public Health Pediatric Clinics serve children in 155 clinic sites in the State. A subcommittee of the Health Task Force of the Study Commission reported that 5,170 visits are made monthly by children to these clinics. Each clinic meets at least once monthly. Two-thirds of these clinics follow the child up to age six and some clinics follow adolescents. The most common problem reported from the Public Health Pediatric Clinic population is feeding. About 1,000 children, at least one-fifth of the visits reported, had feeding problems. Next most frequently reported problems in order were as follows: delayed language and speech, temper tantrums and hyperactivity, excessively fretful, enuresis, psychosomatic complaints, inability to get along, excessive hostility, breath holding, sleep disturbances, and destructive behavior.

When children are seen at the Public Health Pediatric Clinics and the child appears to need help with emotional problems, it was reported that he may be referred to a mental health center, child guidance clinic, developmental evaluation clinic, specialty clinics such as speech and hearing, residential facilities, or to skilled educational help.

Developmental Evaluation Clinics. One of the referral services described above is the Developmental Evaluation Clinic. Twelve of these clinics are strategically placed in North Carolina so that a family may reach one within a fifty mile radius of home. The State Board of Health position paper for the Study Commission indicated that this type of clinic sees 3,600 active patients with an additional 1,083 new children registered annually. It is estimated that the Developmental Evaluation Clinics see about one-third of the young child population of the State. More developmentally retarded children (broadly defined) are seen by Developmental Evaluation Clinics than are seen by similar clinics in any other state.

Outpatient Hospital Clinics. Another source of help for the young child are the outpatient hospital clinics in the State. Five outpatient hospital clinics of the State report that the following child services are available: psychological testing, psychiatric evaluation, psychiatric treatment, ministerial counseling. A significant observation has been reported by outpatient clinic personnel who explain that clinics are divided into specialty clinics; a child is seen by specialists, not recognizing or distinguishing emotional disturbance as a diagnosis. One of the seven clinics estimated that 3 per cent of the children seen in the specialty services are disturbed.

Private Practitioners. Private practitioners who are chosen by parents and who provide private care have contributed information to the Study Commission about the extent of emotional disturbance in children. Responses of 150 physicians (pediatricians and general practitioners) report that they see emotionally disturbed children, 133 reporting that they see 1,205 such patients a week and 17 reporting that they see such patients occasionally. In a New York City study, pediatricians estimated 25-30 per cent of their child patients were emotionally disturbed.

TABLE 2. NORTH CAROLINA CHILDREN SEEN BY PRIVATE PHYSICIANS WEEKLY, 1970

By Age and Symptoms
(133 North Carolina Physicians Replying)

	Ages of Children		
	0-5	6-12	13-18
TOTAL NUMBER OF CHILDREN			
With Problems	584	698	467
SYMPTOMS			
Mental Retardation	157	99	59
Hearing and Speech Problems	112	106	40
Brain Damage	96	65	34
Behavioral Disorders	167	177	81
Learning Problems	38	140	55
Emotional Reaction to Physical Handicap	29	28	27
Psychosomatic Disorders	101	220	167
Psychosis	16	25	29
Drug Abuse			33
Number you treat yourself	701	633	305
Number referred for diagnosis and/or treatment	235	247	130
Number you wanted to refer but could not, for any reason	68	79	47

Mental health professionals in North Carolina have described for the Study Commission the children in their active private case loads. These professionals include psychiatrists, social workers, psychologists, neuropsychiatrists, special educators. One hundred twenty-two mental health professionals reported that they saw 2,115 patients for diagnostic purposes and 507 patients for treatment.

TABLE 3. NORTH CAROLINA CHILD PATIENTS OF PRIVATE MENTAL HEALTH PROFESSIONALS, 1970

By Diagnostic Age and Treatment Age (122 Mental Health Professionals Replying)

	Diagnosis Ages			Treatment Ages		
	0-5	6-12	13-18	0-5	6-12	13-18
Total Number of children*	375	693	1,047	27	193	287
Classifications (Primary Disorder)						
Mental Retardation	69	30	355	3	14	2
Hearing & Speech Problems	8	1	2	2	1	0
Brain Damage	4	13	20	2	6	11
Learning Problems (any etiology)	22	78	154	1	49	59
Situational Reaction	16	46	45	5	27	49
Neurosis	10	26	102	7	32	56
Personality Disorder, Acting Out	11	16	144	2	40	53
Personality Disorder, Passive	3	10	39	1	28	24
Psychosomatic	1	9	32	1	9	12
Psychosis	2	5	42	2	15	41
Drug Abuse	0	0	21	0	1	37

Total numbered referred elsewhere for additional services = 1,437

* Numbers in active case loads

Mental Health Clinics. North Carolina reports 55 Mental Health Clinics, including five Child Guidance Clinics, which serve the counties of the State. Thirty per cent of the 39,809 patients are estimated to be under 20 years old, according to the State Board of Mental Health. The Task Force Report on Mental Health Clinics reported 5,921 children under 18 were seen by these clinics in 1968-69. If the number of 5,921 children seen by mental health clinics of the State is compared to the 1,836,304 child population of the State, it is apparent that comparatively few children are being treated in clinics for emotional problems. By commonly accepted national estimates, at least 10 per cent of the child population needs assistance with emotional problems. In North Carolina less than one half of one per cent of the estimated need is being met through mental health clinic services.

The Mental Health Clinics Task Force attempted to collect information about types of problems of children by age groups. For example, the following diagnostic information was requested regarding child patients, ages 0-5, 6-12, 13-18: behavioral reactive learning problems, neurotic, character personality, psychotic, psychosomatic, and others. However, records appear to be available on an age and sex basis only.

The Mental Health Clinics Task Force indicated that individual clinics reported the number of child patients ranged from 529 to 0 within counties of the State. The percentage of child patients to patient load of the clinics by counties ranged from 70 per cent to 0 per cent. The following tables indicate some of the differences in child patient loads among mental health clinics within regions and by counties. For additional information concerning all counties, see appendix for the full table. Prior to 1968-69, mental health centers were not required to provide children services to be eligible for federal reimbursement of programs.

TABLE 4. ADMISSIONS TO MENTAL HEALTH CLINICS — NORTH CENTRAL REGION

	Total County Admissions to Clinics	Admissions Under 18	Percentage Under 18
NORTH CENTRAL REGION			
Guilford	1,022	288	28.1
Forsyth	790	196	24.8
Durham	677	244	36.0
Franklin	109	29	26.6
Person	113	25	22.1
Granville	37	26	70.2
Warren	33	4	12.1
Surry	10	3	30.0
Yadkin	5	0	0.0

TABLE 5. ADMISSIONS TO MENTAL HEALTH CLINICS — WESTERN REGION

	Total County Admissions to Clinics	Admissions Under 18	Percentage Under 18
WESTERN REGION			
Mecklenburg	1,007	214	21.2
Buncombe	462	137	29.6
Rowan	556	266	47.8
Henderson	212	42	19.8
Burke	216	7	32.4
Haywood	104	39	37.5
Caldwell	169	15	8.8
Clay	27	13	48.2
Yancey	18	1	5.5

TABLE 6. ADMISSIONS TO MENTAL HEALTH CLINICS — SOUTH CENTRAL REGION

	Total County Admissions to Clinics	Admissions Under 18	Percentage Under 18
SOUTH CENTRAL REGION			
Wake	1,740	434	24.9
Cumberland	1,174	529	45.1
Robeson	518	215	41.5
Cabarrus	412	146	35.4
Randolph	317	94	29.6
Lee	278	154	55.4
Davidson	263	35	13.3
Union	17	8	47.0
Sampson	33	6	18.1

TABLE 7. ADMISSIONS TO MENTAL HEALTH CLINICS — EASTERN REGION

	Total County Admissions to Clinics	Admissions Under 18	Percentage Under 18
EASTERN REGION			
New Hanover	610	164	26.8
Wayne	479	187	39.0
Pitt	347	85	24.5
Craven	296	132	44.5
Wilson	272	79	29.0
Hertford	147	65	44.2
Halifax	183	36	19.6
Brunswick	9	3	33.3
Pasquotank	12	2	18.3

Social Services. The State Department of Social Services reported to the Study Commission that 80 per cent of 4,000 individuals seen by its services in 1968-69 were children. It is estimated that about 25 per cent of child referrals to Social Services were due to their emotional problems, about 32 per cent were referred because of educational problems. The Social Service Task Force surveyed the ten most populous county Social Service Departments in North Carolina and reported results of the survey. Each social worker in these departments sees approximately 31 children per year, twelve of whom appear to be emotionally disturbed. Of children diagnosed as emotionally disturbed, the distribution is ages 0-5 — 2 children; 6-12 — 7 children; 13-18 — 6 children.

In 1970 the Department of Social Services reported 4,500 children placed in foster homes of the State, one half this number are under Social Service custody. The Department of Social Services reported in its position paper to the Study Commission that North Carolina had 30 child-caring residential institutions, nine of which were licensed by the Department.

Unlicensed Day Care Programs. Many infants, toddlers, and preschool children are cared for in unlicensed programs across the State of North Carolina. Child care by nursery and day care center operators has been a controversial issue before North Carolina legislators for a number of years. Congregate care of the very young has increased due to a higher percentage of working mothers of young children. By opinions of experts in this area, care varies from excellent to neglect. Where neglect is prevalent, the Study Commission suspects an incidence of emotional disturbance among young children so neglected. At this time, due to lack of program licensing and identification of such day care centers, the facts are not known.

Public School Programs. By the age of five or six, most North Carolina children begin contact with the public schools which will continue for about 12 years of their lives. The public school system of North Carolina provides some information about the inci-

TABLE 8. SCHOOL AGE POPULATION (AGE 6-18), 1967-68

By Chief Exceptionality

	Pupils	
Type of Exceptionality	Expected Incidence*	Reported for** Public Day Schools
Speech defect	72,000	22,924
Hard of hearing/deaf	5,296	
Emotionally disturbed (needing special instruction)	24,000	69
Exceptionally talented	120,000	11,351
Learning disability	48,000	18***
Orthopedically handicapped	12,000	218****
Visually handicapped, including blind (needing special instructional arrangements)	3,000	515
Mentally retarded	36,480	
Educable		8,021
Trainable		1,848

*Based on national expectations for North Carolina Public School enrollment base of 1,200,00 except for N. C. State Department of Public Instruction expectations for talented.

**Based on Biennial Report, N. C. Department of Public Instruction, 1966-68 (unpublished).

***Classified as brain injured

****Classified as crippled

(Information from **Report of the Governor's Study Commission on the Public School System of North Carolina, 1968.**)

dence and diagnosis of children who appear to be emotionally disturbed.

Residential Programs. Several residential institutions are operated for educational programs for the child with behavioral and learning problems. The Wright School in Durham, a re-educational facility which provides for 24 children at a time, is operated by the State Board of Mental Health and has served 200 children since its beginning. North Carolina Advancement School at Winston-Salem, operated by the State Board of Education, serves about 90 boys, ages 9-16, for periods of four months. These boys receive education and counseling for underachievement problems, and research information is provided to the public schools.

Other residential schools operated by the State provide for 5,000 children in institutions for the mentally retarded, as reported by the North Carolina Medical Society position paper to the Study Commission. Other State schools include schools for the blind and deaf. Also, some children are placed in orthopedic hospitals for treatment primarily and education secondarily.

Approximately 104 children with emotional disturbance are reported as inpatients in the medical schools of Duke and the University of North Carolina at Chapel Hill.

The North Carolina Society for Autistic Children reports approximately 1,600 identified autistic children in the State. The Society is now working for better identification of such children and better placement and programs, including schooling.

The State operates residential facilities for treatment of emotionally disturbed children. The following units provide for this number of children per year.

Residential Facility		Number of Children
Children's Psychiatric Institute at Butner		
Children's Unit—Murdoch		32
Adolescent Unit—Umstead		26
Children's Unit—Cherry Hospital Goldsboro		33
Alexander Children's Center—Charlotte		30
Camp Haelan—Lake Lure	(8 weeks only)	75

Four facilities were cited by the Task Force on Residential Treatment Centers as being representative of facilities which are developing more specialized services for emotionally disturbed children. These included the Greer Home in Chapel Hill (Baptist Children's Home), Episcopal Children's Home in Goldsboro (Thompson Child Care Services), Methodist Children's Home in Winston-Salem, and Boys' Home at Lake Waccamaw. All are under parochial auspices and receive funds from a variety of sources.

In 1968-69, approximately 371 children under 18 were in residential treatment in four adult State hospitals and approximately 286 between ages 18 and 20.

Camping Programs. In addition to year-round residential programs, several summer camps offer educational and recreational experiences for children with special needs. Eighty-three camping programs responded to a Study Commission survey. Most responses indicated willingness to work with children with special problems. Of the camps responding, the following work specifically with handicapped children.

Number of Camps	Type of Handicap Involved
2	Crippled
2	Diabetic
17	Mentally Retarded (Day Camps) (3 of these also take emotionally disturbed)
8	Mentally Retarded (Residence Camps)
1	Blind and Visually Handicapped

Carolina Boy's Camp, a year-round primitive camping program, located in Montgomery County, will open its doors as a camping program for emotionally disturbed boys in June, 1971. Maximum capacity is expected to be forty to fifty 10- to 15-year-old boys. The program is modeled after the work of Campbell Loughmiller of Hawkins, Texas, and is administered by the Learning Institute of North Carolina. Boys will remain in the program for approximately one year.

Training Schools, Juvenile Homes, and State Prisons. The Study Commission lacks definitive information about children and adolescents in training schools, juvenile homes, and State prisons. The Governor's Study Commission on the Public School System of North Carolina reported that one of every nine juveniles will be referred to Juvenile Court for a delinquent act. There is

no central registry of juveniles who are charged with delinquency nor of the disposition of the charge. The Residential Treatment Center Task Force reported that records indicated that between 1963 and 1968 the total crime rate in North Carolina increased 70 per cent. During the year 1967-68, the crimes of violence increased 10 per cent. In 1969, State prisons reported 1,122 adolescents as prisoners and 1,972 children in State training schools. The Study Commission reviewed with interest and concern the *Report of the North Carolina Juvenile System: Courts, Correction, and Aftercare.* This report was made available through a pilot project sponsored by the Duke Center on Law and Poverty, and an on-site, in-depth study was made of types of programs available to youthful offenders. The Study Commission concurs with the report's declaration of needed assistance to improve such programs.

Special Adolescent Problems. Two conditions in the lives of adolescents concerned the Study Commission, although it was difficult to ascertain the incidence of either condition. These two problems may be described below as drug abuse and teen-age pregnancies.

Two surveys in North Carolina indicate that drugs are used by 20 to 35 per cent of the students in high schools of the State. Approximately 10 to 20 per cent of adolescents use drugs after high school. In 1969, 89 adolescents were convicted of drug abuse crimes. Suicide associated with depressions and alienation was the third most frequent cause of death in college students in North Carolina, resulting in 38 deaths during 1968-69. Drug experts link excessive drug usage to the dissatisfaction of adolescents with the quality of their lives and anti-social identifications.

Teen-age pregnancy is a condition which has increased in the State without the development of programs to assist the teen-ager who faces this problem. Families, schools, and special programs have lagged behind the need for help. A subcommittee of the Health Task Force reported to the Study Commission that one of every four 18-year-old girls is married; one of these three marriages ends in divorce. The major cause of girls dropping out of high school is pregnancy. The typical characteristics of the teen-age pregnant girl are such that she may be the student who most needs her high school education. Twenty per cent of births to teen-agers are premature babies, more vulnerable to mortality, infection, and accidents.

North Carolina reports 8,000 high-risk mothers of new babies every year. Four per cent of teen-agers who deliver babies have been associated with special North Carolina facilities. For example, the State has special programs for such girls in the counties of Buncombe, Durham, Forsyth, Greene, Guilford, Mecklenburg, Orange, and Wayne.

Typically, schools exclude, parents reject, and no one goes with the girl through her pregnancy, delivery, and decision about her baby. Twenty-eight per cent of deliveries to teen-age mothers are illegitimate; the ratio being 57 per cent non-white to 8 per cent white.

For the years 1960-68, infant mortality varied greatly across the State with some counties showing a high mortality rate of 68.4 non-white, 32.7 white; and other counties showing low rates of 13.4 non-white, 7.6 white.

One of the services available to North Carolina adolescents is the State Vocational Rehabilitation Program which can provide handicapped adolescents, chiefly age 16 and older, with treatment, care, education, and other types of special assistance. Vocational Rehabilitation reports that it serves 1,800 juvenile offenders through the Department of Juvenile Corrections only. Of these, 1,080 are diagnosed as emotionally disturbed. This program also serves 6,000 in public schools, grades 9-12, most of whom are emotionally disturbed and mentally retarded. It also provides services through mental health centers and psychiatric facilities. It operates 16 sheltered workshops across the State.

This chapter has reviewed information about children as reported to the Study Commission by its Task Forces and position papers from State agencies. Although the information represents a variety of State resources utilizing diverse methods of reporting, the compilation of facts provide certain types of evidence about children. It is clear that North Carolina has many children who need emotional support and help. The State has no acceptable way of identifying or describing children who need emotional help and support. It is also clear that those who

work with children as parents and professionals in agencies recognize the need for assistance in working with the problems of these children.

The total number of children seen for emotional problems computed from reports of all agencies, State programs, and private practitioners to the Study Commission is approximately one per cent of the total child population of the State. In this count, there may be many overlapping numbers of individual children. For example, an individual child may be seen by a diagnostic evaluation clinic, social services, and a special school program within a year. The one per cent of the child population figure is an estimate only. However, it strongly suggests the need for planning a program of services that will provide for more children who have unmet needs.

Forty years ago a National Conference gave special attention to disturbed children. In 1930, the White House Conference on Children and Youth proposed a statement on the needs of these children. This statement seems appropriate for the consideration of North Carolina leadership on behalf of children. The concept of providing for such children is still far from implementation.

> The emotionally disturbed child has a right:
>
> > To grow up in a world which does not set him apart, which looks at him, not with scorn or pity or ridicule—but which welcomes him exactly as it welcomes every child, which offers him identical privileges and identical responsibilities.
> >
> > To a life on which his handicap casts no shadow, but which is full day by day with those things which make it worthwhile, with comradeship, love, work, play, laughter, and tears—a life in which these things bring continually increasing growth, richness, release of energies, joy in achievement.

Even as early as four years of age, it has been shown that more than 35 per cent of the apparently normal children of self-sustaining families, average in intelligence, have detectable behavior difficulties.

A comprehensive program to prepare the emotionally handicapped child for life's work must include:

> Early discovery and diagnosis which will determine the nature and extent of the handicap while it is in the incipient stages and when the greatest possible benefit may be secured from care and treatment.
>
> Protective legislation which will make a comprehensive program for the handicapped fully effective, safeguarding the interests of the handicapped as well as the employer.
>
> Research which will determine the fundamental causes of mental and physical disabilities and discover the most effective methods of prevention and control of all handicaps.
>
> National and central state agencies which will provide for the integration of national, state, and local educational, vocational, industrial, health, and welfare activities in a comprehensive plan on behalf of the handicapped child.

The following chapters of this report will propose action which North Carolina can undertake in the aspects of planning, training, and research to develop programs for such children.

Chapter III.

Planning For The Future —A Vision Of The Total Child

The purpose of this chapter is to lay the groundwork for a planned, reasoned approach to utilizing resources for better child care. Adequate care of children, as well as a system of child advocacy, will require improved approaches to a child's health and well-being. This chapter will discuss some specific steps which can be undertaken and explore the levels at which they can be more effective.

Need for Comprehensive Plan for the Care of Total Child. North Carolina needs a vision of child care which provides for the total child. This requires a comprehensive plan of child care which coordinates the services of all agencies involved in the care of children. In a position paper submitted to the Study Commission, the North Carolina Department of Mental Health observed:

> It is important to recognize that no one group has a corner on correct questions or answers regarding emotionally disturbed children's problems or how to enhance the mental and emotional development of children. There are large gaps in basic and applied knowledge, but it is apparent that enough is known right now to enable us to make substantial progress if we use what we know.

To effectively use what is known about caring for children requires that long-range goals be shared by state and local agencies. Short range goals based on local and regional needs and resources can be determined at the local level. Such planning will require strong initiative and leadership—particularly at the local level.

The Study Commission feels the best plan for accomplishing this will involve a coordination of State, regional, or local advocacy agencies and existing health, social service, mental health, and education agencies.

In this section, two basic questions will be dealt with: what can be done in the home, school, and community to provide better child care, and what can be done in existing service agencies to provide better care.

Need to Devise Plan to Fit Children Rather Than Agencies or Professionals. A principle underlying the thinking of the Study Commission is that efforts and services should be child-centered, child-oriented. This is the

basic thrust behind child advocacy—a perspective that looks first at the child and his needs, and takes this as the starting point for social action.

We often ask why efforts to help children —especially troubled children—produce so little positive results.

However, once a child-orientation is accepted as the framework for helping children, it can be seen that much of what is done now is misdirected. Relatively little is undertaken to alter environments to *fit* children—to orient the environment toward the child's best interest. Traditionally, it is the other way around. Children are expected to adjust; and when the child fails to adjust, we begin examining the child and concentrating attention upon his behavior—rather than considering the child and how the environment might be changed to fit the child's needs.

On the other hand, too often when the child is moved to another environment, concern for the child's welfare is overridden by concern with keeping the peace and getting the troublesome child out of the way. In such instances, the environment into which the child is moved is not better for him. In some cases, it is worse.

Both these phenomena—the child helplessly struggling to cope with a world for which he is unprepared and the child moved from the normal world to an abnormal environment where his welfare is a secondary consideration—leave the child pushed away from a setting where he can maximize his potential for health and growth.

There is an interrelationship between a child's growth and his environment. If a child is denied the kind of daily experience he needs to grow, which he needs to find a place in life, then he will fail.

The task is to see that the child is in an environment that is healthy for the individual child. It may mean a little extra attention from a specialist for the sixth-grader who is having difficulty adjusting to school. It may mean residential treatment in a special center for the severely disturbed child.

A child's needs vary as he grows up. A great deal is known about these needs and the results can be predicted if needs are not fulfilled.

What should be prevented is denial of basic experiences to a child. This means assuring that a normal child will have access to normal environmental interactions or that a troubled child will be given an environment to fulfill for him the same needs. When these child-oriented experiences are not provided, trouble starts.

Need to Shape Plan to Meet Social Crisis of Our Times. Many children are born with problems which mitigate against health or normal development. Many children are born into environments which are unhealthy—families with problems, communities with problems. Poverty is one of the greatest destroyers of choices. Hunger, abuse, and lack of care cause children to suffer.

Many children develop problems as they enter certain stages of life. The environment is not beneficial, the responses they get are inadequate, the sequence of their development is not optimal. Somehow they are thrown off track. This happens to a great many children when they enter school for the first time and fail to adjust; they are socially unprepared or their learning skills are unready for the concentrated use required in the classroom.

Also there are normal developments in the lives of all children, such as puberty or the onset of adolescence, which places a strain on the child's adaptability.

When speaking about a child's environment, we are talking primarily about the home, or community, and the school. All of these situations call for sensitive, learned responses from the adults who guide children. Many of these situations call for an adjustment of relationship and environment. These are where our efforts to help children will succeed or fail.

Planning, Programs, and Budgeting Shared by Agencies. Much of the apparatus needed for helping children already exists in terms of service agencies. What we must do is make sure that each agency doesn't have to go it on its own, trying to reach all of those who need help. This approach just hasn't worked. The order is impossible to fill, no one can tell who is being overlooked.

Child advocacy would be built from within the community—an alliance of parents and professionals to reach out and bring to the child the special attention he may need, to speak up and make known needs which no one had tried to help.

Outside the family, the school is the largest experience in the life of a child. Public education is one of the most significant characteristics of American life, and the impact of the schools is especially important in North Carolina where a state system of educational experience is offered for all children.

The problems of a child often show up to others for the first time when he goes to school. School is a major shaping force in the lives of children. The public schools are the logical place to begin to look for child advocacy. This report does not recommend using the public schools as the child advocacy agency. This is not the schools' function, although the schools play an important role as advocates for certain needs of children.

It is strongly suggested that consideration be given to the school as a unit of local child advocacy efforts. This is a natural unit for insuring community control and participation in any mechanism affecting the lives of chil-

dren. It is a natural public forum for action in support of children. Local child advocacy groups could create centers for using resources and creating social arrangements most beneficial to children's potentials.

The schools, themselves, are one of the agencies which the Study Commission looked into to determine what might be done to maximize healthy development of children. Children are in school for the greater part of the day. This is the logical and practical time to try to reach a child. Yet, much of the school time of the past has been spent preparing a few students for college entrance. Too little attention has been given to the future of those children who will not go to college; too little attention has been given to the overall healthy development of all children.

The frustrations and problems in schools today have become a major concern of those trying to remedy the causes of children's maladjustments. Other reports have dealt with this more specifically, and North Carolina educators are making efforts to restructure the schools.

The Study Commission would like, however, to highlight one concept it feels essential to children's well-being. We must place the responsibility for learning where it belongs—on the child. Here again, the child-centered approach is important. Instead of children responding to teachers, we are recommending teachers respond to children. The Study Commission's Task Force on Schools reported on this problem and it is summarized as follows.

> Since our society gives schools the task of inculcating cultural and social values in children and legally demands the child's attendance, it appears prudent to ask if the child (and his family) have an educational bill of rights which guarantees the interest and welfare of the child. In planning for and with the child with learning and emotional problems in the regular class, the following is suggested as the right of every child:
>
> That all children be educated as much as possible with their peer group through sufficient physical, educational, and psychological provisions;
>
> That major educational decisions concerning the child not be carried out unless permission, cooperation, and understanding of the decision be obtained from the child and his parents;
>
> That education is a child development process in which the word *failure* has no place;
>
> That a child's school day be planned and carried out with regard to his total emotional and psychological development, identifying and intensifying the feedback processes which enhance this development;
>
> That teachers-in-training have in-depth work with children so that they may better understand themselves and the developmental process called education;
>
> That a child's ethnic, familial, and individual differences be respected and incorporated in educational environments;
>
> That it be insured that destructive, rigidifying, self-fulfilling prophecies about children be prevented from child-environments;
>
> That the child has the right to participate in educational choices through recognition of his interests and his own learning style.

To advocate for the child in the system of education is to advocate for individualized instruction. But this must have a new meaning and a new emphasis. For instance, both older and younger children benefit when older teaches younger. Even siblings of the older child seemed to benefit through a kind of halo effect. Spontaneous, imitative learning has been largely left to chance in school classrooms. Finally, children's own interests must be recognized as beginning points for learning.

Heterogeneous grouping of children may provide the best environment for all of these things to occur. This emphasis would advocate that children be responsible for their learning rather than the teacher lecturing to children. With the latter emphasis, it is easy to blame the teacher for failure. This new emphasis would allow the teacher to structure the child's environment according to the pupil's interests and learning style. The teacher can become a resource in helping the child develop a process of learning rather than telling him merely what A

and B are. The teacher is a manager of group activity and encourages the group to respond to each member's needs. In this kind of child advocating environment the teacher alters the environment according to children's interests, identified learning styles, and recommendations of child specialists. The system would legitimize advocating for individual needs of children.

The next step to assure the success of school based child advocates—neighborhood or regional—is to tie them, in a loose fashion, with our service agencies. The big problem here is no one knows all the service agencies or services available to one another.

A primary function of child advocacy is to act as a clearinghouse of information. The need for someone to perform this function was identified again and again in Study Commission inquiries to doctors and service agency representatives across the State. Frequently even the referral agencies do not have a complete working knowledge of available resources in the community.

The Study Commission found there are many basic facts about children in North Carolina that are not known. Some agencies were unable to answer some of the basic questions about the effect of their operations on children. The very difficulty of the Study Commission in getting responses from some agencies points up the problem here. Often, because of differences in computation or classification methods, it was impossible to collect information about children from various agencies or even from the same agency in different regions of the State. There are no standard reporting methods for all State agencies. Consequently, the little data available on children are often meaningless.

Standards for Programs to Provide for Continuum of Services. A network of services has begun in many areas, although most services are still scattered. The lack of uniform standards for defining mental and physical health and adequate care, along with the lack of an information gathering system, makes an assessment of current work difficult, if not impossible.

The Study Commission hopes this need might be filled by its recommendation for the Governor's Advocacy Comission on Children and Youth, described later in this report. Such a Commission would be able to begin developing the kind of comprehensive inventory of present services for children that is beyond the scope of any one service agency.

How we care or do not care for children is affecting children long before they are born. Good child care is something that is inherited from one generation to the next. The child who is born to an unwed, a teen-age, or impoverished mother is often off to a hazardous start before birth.

Out of every 1,000 children born in North Carolina, 36 are born dead or die soon after birth. The greatest proportion of these children are those of the poor. Recently an infant mortality rate for ghetto infants has been quoted as seven times that of suburban infants.

In North Carolina a baby is born to a girl under 20 years of age every 24 minutes. Pregnancy among adolescents requires special care because of the high rate of complications. The chances are better than one out

of four that the child's mother will have no husband. This again calls for special provisions, both before and after the child is born, to assure that the generally adverse circumstances surrounding illegitimacy—of which the mother's unreadiness is a major factor—do not harm the child. Illegitimacy occurs most often among women of the lowest socioeconomic group—often the group which needs special help the most.

The State Board of Health has repeatedly pointed out the problem that exists for infants of the poor and the young and urged that more efforts be made to identify high risk mothers, direct them to services, and provide the care that is necessary.

Child care, for the poor, remains a problem throughout the child's life. The failure of society to do something about this is one of the reasons poverty—and the disease, lethargy, and helplessness that accompanies it—continues to grip so many citizens.

The first year of life is critical for the child. It is the time when the strongest efforts should be made to insure that the child is protected and cared for. Yet, many infants leave the hospital with their mothers after birth and are not heard from again until something goes wrong or the child shows up for his required preschool innoculations.

North Carolina has a network of pediatric clinics operated by county health departments. The Study Commission is able to make general statements about the care offered youngsters from the response from a number of these clinics to a general questionnaire and personal knowledge of members of the Commission's task forces.

Services in 101 pediatric clinics across the State cover routine screening for problems in development and disease. Specific services vary from clinic to clinic. Almost all clinics now give parents or guardians the opportunity to sit down with a doctor and nurse and discuss such things as diet, growth and development, management of children, and counseling on specific physical or psychological complaints. While a few clinics cover only the first year or first few years, many of the clinics follow a child until the age of six; some clinics follow into adolescence.

The clinics do an adequate job within their means, but their means are limited. Indications are that children are receiving rather limited care. While the clinics may recognize problems, the services to deal with these problems are not always easily accessible.

The Study Commission found that clinics in the counties which have the most facilities recognize the most problems and see needs for more services. This leads to the conjecture that, at best, many children are still uncared for. In those counties with minimal clinical facilities, significant problems go undetected. Indeed, the Study Commission found that when a symptom is noted in a clinic, it is usually seen in a number of children. Other symptoms may not be noted, tending to reinforce the observation that personnel learn to identify a problem or symptom and recognize this only with experience. Also, no single definition of what constitutes a pathological symptom at a given age exists among the clinics.

Many respondents from clinics said the entire range of care for the emotionally disturbed child needs improvement. Chief among their suggestions is that more mental health clinical facilities be established. Another frequent recommendation is that more educational development be made available for their staff. They also feel the need for more nurse consultants and/or resource personnel for psychiatrically ill chidren and hospital facilities for acutely ill children and adolescents.

During the first year of life, and the subsequent first years, the kind of mothering a child gets is very important. Many infants

and children are placed in day care centers where the mothering comes from someone other than the actual mother. Yet effort to insure some minimal standard of care in these centers is almost nil. We have a licensing system, but it is voluntary rather than mandatory. Many centers do not volunteer for licensing.

Getting the child with emotional problems to treatment is still the biggest problem society faces. Many children suffering mental retardation, hearing and speech problems, brain damage, emotional and psychotic disorders simply are not treated. Many children are not diagnosed, and often there is little or no treatment after diagnosis. The child waits, his problems become a deeper part of him.

In most cases, a child's problems go unattended until he enters school and some sort of accomodation is forced. In some cases, nothing is done until the child is a teen-ager and the problem has become acute. If the problem cripples the child or gets him into trouble with the law, again, a forced solution is found. Significantly, one of the areas where the long delay between diagnosis and referral does not exist is drug abuse in adolescents. Once a problem forces itself in a dramatic way, it seems that communities begin to act.

The local mental health clinics in North Carolina see more than 10,000 children and teen-agers each year. These clinics, however, do not have the manpower, the geographic availabilities, or the models for intervention necessary to meet the needs of the broad spectrum of emotionally disturbed children. Moreover, these services are aimed primarily at moderately disturbed children with middle-class, cooperative parents and generally touch very slightly the high risk population or the unmotivated clients.

The mental health clinics are increasing the numbers of services they offer, but this is not enough. We need to do more to prevent emotional problems. Attention to prevention seems impossible because our efforts are in coping with the immediate needs and crisis intervention.

The treatment of emotionally disturbed is often associated with institutional residential centers. These centers are often the end of a road which parents have traveled to help a child. It is unrealistic to hope that the need for residential institutions will disappear. Even with the improvement, expansion, and better coordination of communities' facilities, conflicts will persist that require the removal of a child from home and community for effective treatment. Small communities cannot be expected to provide the facilities and personnel necessary for the treatment of these specialized problems.

Residential treatment centers include programs for children with severe psychiatric handicaps. These include such institutions as schools for brain damaged children and programs for autistic and other mentally ill children who require indefinite hospitalization. The majority of centers, however, are for treatable children of potentially normal or above intelligence who can adjust to group living. These children give evidence of ability to profit from treatment, including school, within a reasonable period and adjust satisfactorily in the community following discharge. The length of treatment ranges from several months to several years.

In North Carolina we have one institution which offers a comprehensive program for the study and intensive treatment of mentally and emotionally disturbed children, along with training of child mental health specialists. This facility, the Children's Psychiatric Institute, is a state-supported child and adolescent center at Butner, affiliated with the Universities of Duke and North Carolina and the residency training program in general psychiatry at John Umstead Hospital.

Other centers throughout the State offer treatment, but are more limited as to the range of children, the severity of illnesses and, in some cases, staffing. For instance, because of a lack of staff, some institutions are not able to follow up discharged children as much as they feel is necessary. Because of lack of personnel, some children's units are unable to offer individual therapy, which puts severe limitations upon the effectiveness of their programs.

No facilities were uncovered during the Study Commission's investigation that offered programs for the delinquent acting-out child. This type of problem is apparently one that present residential treatment centers are not equipped to handle, yet services for such children are badly needed.

Interim programs for children within communities are sadly lacking, frequently resulting in more chronically disturbed youngsters by the time residential centers are contacted. The interaction between the majority of institutions and the child's community is minimal. When a child has been placed outside the community, there seems to be little responsibility felt for the child in his home community. There needs to be a closer working relationship between the institution and the child's home resources.

Children under 18 in the four North Carolina state mental hospitals for adults receive little more than custodial care and no follow up. Most of the children are adolescents, ages 13 to 17. All of the hospitals lack child mental health professional staff or organized programs for children. Some have well-developed vocational rehabilitation programs which involve the adolescents at various times throughout the day. However, individual therapy, as is education, is extremely scarce.

In addition, these children, stuck away in what are essentially adult hospitals, are subjected daily to an abnormal environment scarcely conducive to mental health. The risk of harmful influences from the disturbed adults is considerable.

What services exist for the youngster who breaks the law? The system of juvenile justice and correction in North Carolina seems largely ineffective, severely fragmented, and in need of a major restructuring and redirection.

The task force investigating this segment of child care agencies and institutions found

confused and irrational administrative patterns. These patterns are almost totally ineffective in developing recruitment of qualified staff, in-service training programs, channels of communication between components of the system, and information base to determine whether youth are being helped.

There is, in fact, no way of knowing at present whether the system is correcting and controlling delinquent behavior. It may well be that the diffusion within the system leads to an experience for many adolescents that contributes to their difficulties rather than only failing to help them with their problems.

Court service programs have primary responsibility for community based services for delinquent youngsters. Moreover, the court service programs in North Carolina follow a traditional and rather stereotyped pattern. They are characterized by large caseloads, few specialized services to meet particular needs, little experimentation with new methods, no real effort to evaluate effectiveness, little emphasis on in-service training, and ill-defined standards of performance.

There are exceptions to this pattern and many capable people in this service have good and helpful relationships with their youthful clients. The point is that, given the fragmented administrative structure through which these services are rendered, it would be unreasonable to expect anything but an inadequate program.

Community based programs which provide a variety of imaginative services capable of engaging the juvenile offender in a behavior changing experience are the backbone of any good correctional program. North Carolina does not have this and is unlikely to have such a system without restructuring and redirection.

In some counties juvenile delinquents are handled through family counseling services placed inappropriately under the administrative offices of the courts, with no background in juveniles. In counties which do not have family counseling services, the services for the juvenile delinquent are handled by the local social services department. Because of the press of delivery of a variety of other services, the social services department is forced to give services to juvenile offenders a very low priority.

When a child is institutionalized, he is shifted from the care of one agency—the administrative office of the courts or local social services—to another. Coordination is difficult. The way in which institutional programs for juvenile offenders have developed historically in North Carolina has led to the present situation. Very large institutions are isolated both from home communities and the treatment resources of the larger urban centers. Perhaps because of their isolation, a strong emphasis has been placed on educational programs in these institutions which tends to call for longer periods of incarceration than would specialized treatment services coordinated with local community resources.

A number of young people are committed to institutions for non-criminal offenses. They are housed and held as long as those committed for more serious delinquent behavior. Diagnostic and treatment resources

and personnel at the institutions are inadequate. Records and follow-up studies which would provide a base for evaluation of program effectiveness are unavailable.

In general, the fragmentation between community and institutional programs minimizes the possibility for flexible use of specially designed programs to meet the individual needs of children. Varying lengths of individually determined periods of treatment in small community based facilities is not possible currently.

The tendency of North Carolina courts to commit children indiscriminately keeps the institutional programs overcrowded with children who could more effectively and economically be treated in their home communities. This makes it difficult to develop institutional programs geared to the needs of young people who actually need them. When a person goes to an institution and returns to the community, he has been passed from one component of the system to another and back again. As important as is the process of returning to the community, it has traditionally been, and remains, the low priority of court service programs.

No more than lip service is given to following the adjustment of the juvenile offender after he is returned home. We know little of what actually happens with after care because no records are systematically kept. Little is done for and with most youngsters who return to their communities; they too frequently become involved in more serious offenses as adults.

In most instances, the police are the first contact a youth has with the juvenile justice system. While police officers cannot be expected to be skilled practitioners in the mental health field, it is important that those who work with juveniles are aware of emotional problems. Only in this way can they be sensitive to the youngster's needs and to be able to relate to him.

Among the State's hundreds of local police and county sheriff departments, less than fifteen specialized juvenile law enforcement programs exist. Those that exist probably achieve a fairly high degree of effectiveness by virtue of the fact that the trouble has been taken to appoint one or more officers in those programs. Several major communities of the State have no juvenile police programs.

Judges who deal with youngsters usually have had no special training for their jobs, either in the study of juvenile law, or in order to specialize for practice in the juvenile jurisdiction following election to a district court judgeship. Judges, as other people, have their biases which they bring with them to the task of hearing juvenile cases. With no special orientation to this demanding role, they must of necessity go through a period of adjustment to hearing juvenile cases and rendering wise decisions, often with little professional assistance. At best, this kind of learning process takes some time.

The Study Commission feels that the pattern of rotating judges within the various jurisdictions of the district court almost assures that the kind of learning and specialization needed to become a good juvenile judge is impossible. The Study Commission also believes that the method of election is probably not the best manner by which to select the kind of person needed for this position.

With adolescence comes a stage in which problems blossom. During adolescence, the youngster is confronted with a number of challenges. He must separate from his parents, but he must do so in a manner which doesn't reject them or their positive attributes. He must determine and accept his sexual role and develop the capacity for lasting relationships. He must develop a value system for achieving self-identity and realistic goals. He must choose a vocation and begin fulfilling his potentials in productive work. These challenges are seldom met smoothly; that is natural. But at times the mistakes are so large that they throw the adolescent completely off track and threaten the possibility of his ever getting headed in the right direction. One of these mishaps is pregnancy.

What's being done to prevent unwanted pregnancies among adolescents in North Carolina? We do not really know too much about what is being done. Teen-age pregnancies is a troublesome problem rendered all the more troublesome by society's lack of frankness about sex, particularly with youngsters.

The effects of prescribing contraceptives to adolescents who have already borne children or the sexually active adolescent is not known. We do know that contraceptives, knowledge and availability, is not the answer to the problem; some pregnant adolescents were apparently well informed about contraceptives.

The pregnant adolescent has especially difficult adjustments to make. Pregnancy complicates an already complicated life for the adolescent. Separation and independence from parents may occur before the adolescent is able to cope with the obligations of being independent or having children dependent upon her. The development of values and goals may be confused by turmoil or hindered by incomplete maturation. With limited capabilities and the sudden need for a job, a vocation may be chosen far below the potential of the individual. A sexual partner, although he may have been sought out of need to be loved or a relatively lengthy courtship, may have been chosen before either partner developed capabilities needed for a lasting relationship.

Many of these youngsters still need help —more than ever before—as they make a rather abrupt leap from childhood and youth to the responsibilities of an adult. An educational program is needed to inform and encourage educators, health and social service agencies, legal groups, and the general public to face the facts about the size of teen-age population; the increasingly early age of sexual activity; the increasing number of early marriages with their instability; the number of babies born to school age girls; the high health risks for young pregnant girls and their infants; and the multiple educational, socioeconomic, and psychological needs of adolescent parents and their children. It is important that we provide for these adolescents within an educational structure and provide them with the special services they need.

Those concerned with advocating for youth should study and provide the appropriate comprehensive services with an integrated multidisciplinary approach to the interrelated health, socioeconomic, educational, and mental health needs of pregnant adolescents and young parents. We need more research to form a basis for developing more effective counseling, management of adolescent

pregnancy, prevention of precocious pregnancy, provision for child health and care, and stabilization of adolescent families. Alternative opportunities for continuing education should be provided by public school systems for pregnant school girls where population size makes multidisciplinary centers impractical.

Counseling, vocational guidance, training, and assistance in obtaining employment should be made available for young fathers as well as young mothers. A preventative program in the public schools is needed to provide instruction and guidance on biologic and social development, responsibility for one's behavior, and the values of family life. There is a great need for enlightened, original, individual counseling. There is also a need for clarification of ethical, professional, and legal considerations in dealing with minors, in relations in such areas as the provision of contraceptive information and materials, therapeutic abortion, venereal disease treatment, medical examination and treatment. The establishment of crisis clinic services in local communities for brief or intermittent services to adolescents would be helpful. A key factor in whether we are to have better services for the adolescent in this area is the leadership that comes from the top level of State services and public instruction.

This chapter has identified some of the needs for planning on local and State levels in order to advocate for the young of the State. A number of persistent problems of children and youth has been identified and some suggestions made for improvement of programs. A system of child advocacy councils is suggested as the mechanism by which concerned citizens can identify the extent of local needs, and can tap into regional or State resources in order to improve conditions for the young.

Chapter IV.

New Approaches To Training Those Who Work With Children

Comprehensive planning for services as suggested by the Study Commission requires new concepts of training those who work with children. Few children's problems fit into the disciplinary lines of highly specialized professions. A new concept of training is needed which recognizes interdisciplinary training. The person entering nursing, education, psychology, social work, psychiatry, or other disciplines must be familiar with more aspects of a child's life than those covered in his specialty.

One new concept of training suggests that the basic training of all persons in the helping professions provide an understanding of child development. This is especially important to those in the mental health profession who, in working with the child or adolescent, need to understand the meaning of each individual's experiences in order to be of help to him. Various experiences in the life of a person as he develops may be remembered by him as painful, lonely, enhancing, or reassuring. The meanings that he imputes to his experience become involved in his development. This fabric of past experiences and their meanings is related to the way he sees his future and the way he approaches other experiences. These are some of the reasons why it is helpful for mental health personnel to understand the dynamics of the growing child.

Training programs should emphasize how the child *becomes* an adult or grows towards adulthood. In general, this development may be described in phases such as conception, infancy, toddler, school age, teen-age, and older adolescence. However, sometimes training emphases can be misinterpreted, concentrating unduly on the differences in phases or the differentiation of phase from phase. Emphasis should be put on the continuity of development of the person which proceeds, unevenly, towards maturation.

If the child is taken as a theme for training and personnel are to be trained *to work with the children in their environment* as much as possible, some changes are in order in training programs.

The Child in His Natural Settings. Tracing a child developmentally, he develops within his mother as a very dependent beginner. This dependency on an adult continues after

birth for some weeks, months, and years. The young child as he appears to others is as the newborn, the baby, the toddler who begins to move away from home base. Those who work with the child are those in his home or in his care center, relatives who enter into his care, little playmates, doctors who see him periodically and when illness strikes, and his first teacher in nursery school if he attends one.

The young child's environment suggests that training programs should involve those people, including parents, who care for the young child. Other persons being trained to work with older children should also have direct knowledge of the development of the younger child. It is suggested that such knowledge be derived, partially by observation of children and their caretakers, contacts with the child in his environment, watching his play, his tantrums, his exploration, his early development of language, motor skills, and relationships to adults.

As children grow older, they are found in milieu several steps away from home. For example, some children (between the ages of three and six) attend nursery school, play centers, or kindergartens for half days or full days. They play in neighborhood groups; they go to church schools; they go to doctors' and dentists' offices and clinics.

Some children, by the age of six, have had contacts with a variety of child specialists due to needs for diagnosis, treatment, and remediation of specific difficulties. Some children have responded well to various vicissitudes of life and have no contact with child specialists. They have already developed patterns of response to separation from loved ones, hospitalization, poverty, and other circumstances. Other children fight, cry, become silent, and gradually lose hope for help with their lives.

The settings through which children have moved with or without special help suggest the places in which child-helping persons should be trained. Ghettos and streets and schools can become training sites along with the more traditional settings of hospitals and clinics.

The typical daily setting for the child, age six to eighteen, are the schools which he attends for about twelve years. Schools offer a training laboratory which is unparalleled as to studying children in a public institutional setting. Approximately all (school-

age) children in North Carolina attend school; most are enrolled in public schools. In the school setting, the child can be studied as to his relationship to authority, to directed learning, to informal activities such as play groups, to group relationships paralleling a large family. Personnel can be trained to understand the meaning of behavior, its antecedents, and effective intervention.

The school seems to be a logical place where some training should take place regarding the child-helping professions. Yet many schools have felt pushed to do so much for so many children that the mental health training function has not evolved very far in public schools. Strides have been made to insure that teachers begin their teaching with more adequate training. Efforts have been made to offer training to teachers during the school year and summers. But the full potential of utilizing the schools as a training laboratory for a variety of professionals who want to understand this aspect of child life has not been tapped.

As children become adolescents they have more freedom to come and go, more responsibilities, and distance between them and their homes. Environments such as camps, clubs, part-time jobs, boarding schools, street gangs, teen-age coffee houses, communes, drug houses, group hang-outs, drive-ins, love-ins, beach parties enlarge the context in which adolescents move and live. Their experiential base is greatly magnified. The meaning of their experiences is complicated by the emergence of interests in sex, new experiences, values, and the future.

Traditionally, the environments described above have been supervised by group work personnel such as club or camp counselors, by employers, or by various community youth workers. Many of these environments are unsupervised. Part of their appeal for adolescents is derived from the absence of adults, supervisors, or trained personnel.

When trouble brews or erupts, the adult world intrudes into the adolescents' world in the persons of police, juvenile officers, social workers, the courts, or in the adult decisions to change the environment for the adolescent. Troubled adolescents frequently are moved out of their environments. They are sent away from their homes to a variety of types of residential schools or hospitals or to detention homes or jails or unwed mothers' homes. If adolescents are in boarding schools when they become involved in troubling circumstances, quite often they are sent away from their school environment and returned to their homes. These shifts in environment, separating the adolescent from the world of adults, make it difficult to set up adequate training programs for those who wish to work with adolescents except in controlled, artificial settings.

Training Programs to Include Traditional and Innovative Programs. Up-to-date training programs for those in the helping professions offer, along with the more academic offerings, clinical experiences with children and adolescents in their natural settings. Such training should enable a trained person to gain better understanding of the world in which the child or adolescent lives. It should also enable the trained person to more effectively produce results in his job — that is, it ties training to job effectiveness more closely.

The Study Commission recommended that training of new professionals, assistants, or aides utilize traditional and innovative approaches to training.

Traditional approaches to becoming trained vary from one child specialization to another. In general, most persons in the helping professions spend about 7/8 of their training period reading *about* or listening *to* or talking *about* ideas of children. Notable exceptions to this use of time are the professions that early involve the trainee as directly as possible with a child or a group of children. Most programs now recognize the need for supervised experience or supervised internship.

Need for Early Clinical Experiences. The Study Commission suggests strongly that training programs develop the concept of a team of trainers or co-trainers, combining the academic approaches and experiential approaches. Persons skilled and proficient in the delivery of services with children would be co-trainers with the formal academicians who provide the theoretical framework, the general knowledge, and applicable research findings related to the field.

The goal of a training program should be to produce those kinds of child-helpers who are effective with children, who find satisfaction in work with children, and who enable children to become more self-directive, more loving, and more at ease with themselves and others. Early in a training program, a trainee should have some opportunity for direct work with a child. This experience should help him assess his way of relating to children, and some insight into his own feelings of comfort, challenge, or distaste with such work. Some professionals, notably social workers, nurses, child psychologists, and child psychiatrists, have worked hard to provide for this type of clinical experience in their training programs.

Initially and throughout the training program the trainee should profit from his association with his supervisors, trainers, or preceptors. It is recommended by the Study Commission that these training roles be filled by co-trainers, representing the formal aspects and clinical aspects of training. Some

of the early work of the trainee should be in the environments similar to those for which he is being trained.

Need for Interdisciplinary Training. The Study Commission recommends that interdisciplinary training should come during a person's regular training for his specific work. Training programs should provide an early chance for work with children and adults in a variety of settings that extend beyond the boundaries of one profession.

Members of a training team should not only have a variety of backgrounds as to experiences, specific skills, and knowledge, but they should also represent views of the child which assist teams in getting the total picture of the child's problems. Teams should include persons who understand the health, mental health, social, and educational aspects of child development.

Traditionally, persons trained in child professions have included nurses, pediatricians, social workers, child psychologists, child psychiatrists, and others. Child guidance clinic teams have traditionally included three of the above; pediatric centers have included two or three of the above professionals. The tendency in the past has been for the traditional team to consider the child as a patient, his parents as clients.

A modern concept of a training team may include a variety of professionals, the team extending to include the child's teacher, his minister, or other interested adults who can identify with the child and contribute insight into the problem and the treatment.

A modern training team involves the parents in decision-making and in the reeducation of the child. Often parents can contribute perceptions about the child and to the collection of information about him. Many parents also are intuitive as to how to help their children. Parents may take a more active role with helping professionals to understand children, and parents may act as participants with professionals in child treatment.

Whereas training as a child specialist in one aspect of child development represents very reputable training programs, new programs will emphasize the interdependency of training. The impact from new knowledge, new evidence in the science of interpersonal relationships, new discoveries, is a major one. No one professional has all the answers or represents the dominant discipline in child study. Part of the challenge for professionals is to assist each other in integrating findings and developing a more lucid structure of knowledge of child development and of how adults can truly help children.

Multidisciplinary training also increases the probability that the trained person will know how to use resources of multidisciplinary teams in actual practice. The well-trained person will have developed respect and utility for another's skills while he is in training.

A broad range of professionals are concerned with the happiness and well-being of children — educators, health personnel, ministers, group workers, juvenile law and court personnel, social workers, psychologists, and psychiatrists. At present, not enough of these people are being trained to handle the problems of children.

In the opinion of the Chairman of the Study Commission, the lack of training programs and the comparatively small number of mental health professionals being trained currently in North Carolina appears as the most striking finding of this entire Commission's study. For example, the Task Force on Training of Professional Personnel presented the following facts about personnel being trained.

> Approximately 35 nurses graduate each year from the University of North Carolina School of Public Health in the master's program of mental health, maternal child care, and generalized public health. Two master's programs in Schools of Nursing, one in Greensboro and one in Chapel Hill, graduate approximately 40 nurses a year. Ten baccalaureate programs graduate about 1,500 students; 20 diploma schools, 1,200; associate degree programs, 500. Licensed practical nurse programs prepare 1,200 practical nurses a year.
>
> The University of North Carolina and Duke University awarded 26 doctorates in clinical psychology in 1969 and 1970. Several other universities are developing doctoral level training programs in North Carolina with North Carolina State University graduating its first Ph.D. in clinical psychology in 1972.
>
> Approximately 245 medical students

graduate each year from the three North Carolina medical schools. Little emphasis is placed on the psychopathology of childhood or the treatment of emotional illness in children, except on an elective basis.

There are about 80 psychiatric residents at five hospitals. Currently there are five unfilled general psychiatry residency positions in North Carolina. A total of about 18 child psychiatry fellows are being currently trained at three medical training centers.

Departments of education in colleges and universities reported that they are training teachers of emotionally disturbed, school psychologists, and school counselors. These departments made the following report for 1970: two programs training teachers of emotionally disturbed, 13 graduates; one program training school psychologists, 4 graduates; two programs graduating a total of 48 counselors. For undergraduate or graduate teacher preparation programs, no courses are required in child developmental psychology or mental health practices in classrooms. Neither is such training required for principals, supervisors, or administrators of schools.

Other preparation programs for professionals who work chiefly with human services provide no basic training in child problems or the special understanding of the child or adolescent. For example, law schools, dental schools, etc., make no provisions for training in this area.

No report was available for departments of social work in the State.

The problem of providing too few trained professionals to do child work in the State is not a new problem. The fields of health, mental health, and social services have traditionally been understaffed with more demand for professionals than professionals available to fill the need. This is especially true in the child professions which usually require longer duration of training.

New Approaches to the Continuum of Training. The Commission suggested that new approaches be implemented in terms of graduate and undergraduate programs. Its suggestions would break the frozen mold of requirements which were appropriate for

another era and attempt to provide matrices of training opportunities. Assistants, aides, and other personnel could move up a ladder of more extensive training as appropriate. Or they could move over from one job into another of similar depth of training but with different emphases. Some programs available only to graduate students traditionally, like child psychology, might be introduced to undergraduates. Other programs with lengthy post-graduate training like child psychiatry might be telescoped into shorter duration of training.

The Commission recommended that training institutions find ways to cooperate in the development of matrices of training opportunities. Such cooperation would involve high schools, technical schools, community colleges, undegraduate colleges, graduate and post-doctoral programs.

Need for State Leadership in Training. Leadership for this kind of collaboration appropriately comes from State leaders in mental health, education, higher education, health and medical affairs. Such leadership should insure provision for professionals to continue to learn on their jobs. Some of this continuing to learn is fostered by in-service courses, scientific institutes, self-studies, continuing education, state professional meetings, symposia, etc. State leadership can do much to insure against the fossilization of ideas that occurs when personnel are not continuing to respond to new developments. Such insurance is necessary if the delivery of services to children through trained personnel in the State does not become, like inanimate equipment or facilities, obsolete.

Training for work with children is not available in all regions of the State. Institutions and agencies across North Carolina — universities, community colleges, hospitals, technical schools — should cooperate to provide special courses to help develop skills for working with children and families.

A promising practice has developed for the concept of multi-versity approach to training personnel to work with children. For example, leaders from several university programs for child psychiatry and from programs for social workers, along with leadership from the State Department of Mental Health, meet regularly to discuss training programs, sharing personnel, improved practices, etc. These groups might form bases from which program development, regional training centers, and other statewide training needs could be studied and acted upon.

The Development of Regional Training Programs. In the Commission's study of available manpower to meet the needs of children of the State, it appeared that there is a startling low quantity and quality of trained manpower. The Commission recommends that training opportunities be provided to those who need training and in geographical areas where they may continue their work or in geographical areas with special need for services.

The most promising approach to the solution of this problem appears to be a Regional Training Program developed along the lines of a model applicable to various parts of the State, allowing for modification within each region as to its strengths, its needs, and pressing problems. A Regional Training Model would offer a program which had the following characteristics:

It would serve a large enough population requiring special services for children; that is, health, psychological, psychiatric, etc.

It could support a variety of specialists working together from the same base for programs for children.

It could be created as a new mechanism serving needs of local municipalities and helping the state level efforts deliver services closer to where needs are.

It could draw together a variety of fragmented services, already funded; provide such services a unifying program base of operation; facilitate communication among individual efforts.

What kinds of services might be offered by a regional training program? Services might be available to a spectrum of needs of communities in the region. The following services are some which might be needed from such a regional training program.

Counseling and care of teen-age pregnant girls in connection with continued education opportunities.

Assistance to agencies regarding infant care, counseling for new mothers, child placement agencies, etc.

Assistance with programs for day care of small children (health, social, emotional, and educational develop-

ment); assistance to parent education and collaboration with day care centers.

Consultation to schools and their personnel regarding special problems of children in kindergarten and elementary schools, especially in the areas of diagnosis, and translation of findings into meaningful instruction for individual children.

Collaboration with schools in formulation of mental health programs for all children and for assistance to teachers in the promotion of healthful environments for learning.

Consultation and assistance to community agencies, organizations, parents' groups interested in child development programs for the region.

Special help available in child mental health problems as they relate to major social concerns of the region and programs designed to alleviate them (such as drugs, poverty, juvenile delinquency, child abuse, prejudice, etc.).

The Regional Training Program would offer training opportunities to those who wanted to develop special skills in the programs described above. The opportunities should be available in a variety of settings. These would include typical provisions of outpatient clinics, hospitals, consultation in agencies and schools, emergency centers and long-term inpatient treatment sites. Opportunities would be provided also for the development of child sites such as schools, neighborhood centers, day care programs, etc.

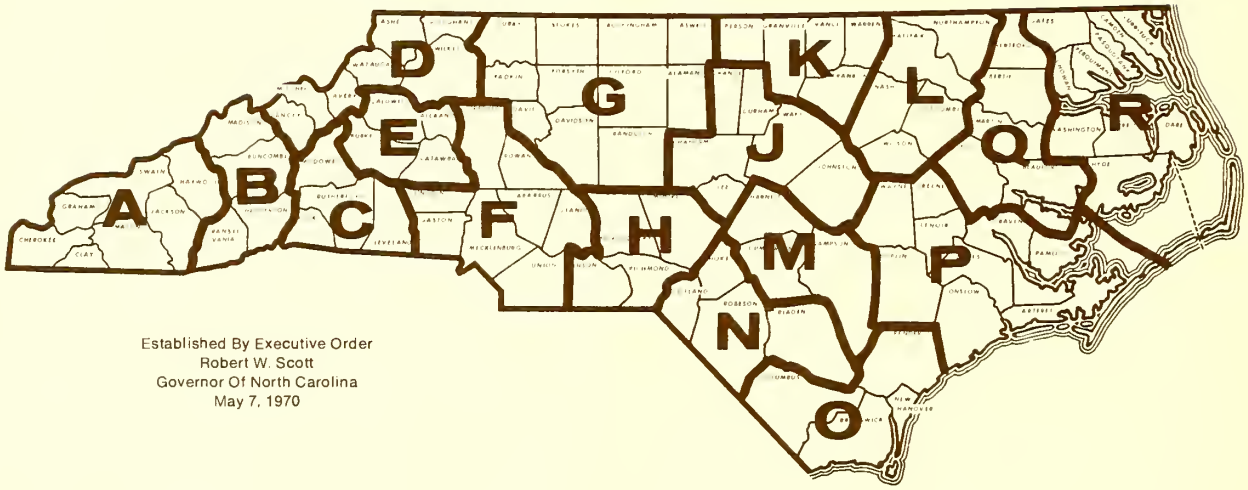
For whom would Regional Training Programs provide training? A number of persons, like those below, indicated they would like to participate in training activities related to their work with children.

- Parents
- Aides or Paraprofessionals
- Teachers
- Counselors
- Social Workers
- Probation Officers
- Nurses
- Ministers
- Lawyers
- Psychologists
- Physicians
- Pediatricians
- Obstetricians
- Gynecologists
- Psychiatrists
- Child Psychiatrists

Ideally, a Regional Training Program could offer or help coordinate the available offerings, utilizing multiple approaches to the types of training. Training should be available through short-term or long-term offerings to trainees. For example, specific mini-courses or specific short-term on-the-job training might be offered for certain types of skills, concepts, or new developments in the field. Longer term training involving several years of work might be developed in collaboration with degree granting or certificating institutions. Actual supervised work in the laboratory of the region would provide the trainee with direct ways of learning on the job. It would help close the gap between preparation for the job and producing effectively when one enters his work.

The Development of Manpower. A secondary benefit of such a regional training concept with trainees in the region is that it would provide another level of manpower in the sites. Although supervision requires time of the professional in the site, his investment would yield the benefit of the trainee's help and assistance in the full spectrum of work necessary in the site.

NORTH CAROLINA MULTI-COUNTY PLANNING REGIONS



Established By Executive Order
Robert W. Scott
Governor Of North Carolina
May 7, 1970

What if a trainee was not able to function or contribute positively in the site location? His supervisors or trainers would have job samples or direct experiences to assist a trainee in redirecting his efforts or reassessment of his goals. Training in actual sites where work is done with children affords trainees and trainers a unique opportunity to discover and keep discovering the field — that is, the world of work with children.

Questions appropriately will be asked as to how a regional training program might relate to current offerings of universities, colleges, schools, community colleges, clinics, and adult education within and outside the region. No doubt negotiations between the regional training center and the various institutions would be conducted regarding the following: admission to courses, costs, instructors and supervisors, suitable site locations, standard of training, content of training experiences, evaluation of productivity on the part of the trainee and trainer, credit applicable to certificates, degrees, etc.

In North Carolina some centralized functions at a state level might give leadership and assistance to helping a regional training program negotiate its programs within the region or to bring others into the region to assist it. For example, State Departments of Mental Health, Public Instruction, Health, Social Service, the Learning Institute of North Carolina have utilized regional concepts for planning and program development of regional training programs for work with children.

In 1970 the Governor's Office established 17 Multi-County Planning Regions based on the factors of economic and social interrelationships, existing cooperative programs among counties and municipalities, a population base of at least 100,000 people, and the existence of natural barriers that might separate one region from another. Each planning region consists of at least three counties. These regions were designated due to the need for provision of quality public services (health, medical facilities, schools, etc.). Prior to the designation of 17 regions, North Carolina had been divided over 70 different ways by State organizations for special purposes. Therefore, State leadership has already pointed the way for cooperation at a regional level for all State agencies.

The Development of Common Principles. In any training program the question of theoretical models is important. A leading social scientist has said nothing is as practical as a sound theory. Those professionals interested in training have, traditionally, identified a theoretical model — or in rare

cases developed one — which serves as a framework for their thinking, their training activities, and their program development.

As a basis for work with children, theoretical models may appear to vary greatly as to the interrelationship of causal factors with behavior, as to the relationship of the child with his environment, as to the nature and process of learning, and as to the relationship of psycho-social and intra-psychic elements in child development.

Most child training professionals are not theoreticians. They are very interested in building systems of thought based on theories. Professionals utilize theories to formulate approaches to problem solving. They adapt parts of theories to formulate applications or treatments for specific situations. Professionals, faced with reality situations, translate theoretical ideas into principles which may be applied to the formulation of solutions.

Differences in diverse theories cannot be resolved in the pure theory sense. For example, there are obvious differences in philosophical and psychological bases of theories such as Gestalt views of learning, behavior modification or stimulus-response learning, and child psychoanalytic theory. Theoreticians vary as to their special interests in cognitive, affective, or psychomotor domains of development. Theoretical arguments regarding nature versus nurture, environmental versus individual growth determinants have persisted at least for the past two generations. Proponents of each theory select from new findings those aspects which fit their theory to provide further supportive evidence for its perpetuation.

Adaptations and accommodations can be made to evolve principles upon which programs can provide training for competent child workers. Various principles developed from theories will be helpful to any child worker if he can gain insight into positive ways to help a child deal with his environment. Professional workers will need opportunities to choose, select, test, and use concepts and evaluate those which enable them, as unique individuals, to deliver competent service to children. Child workers can find much that is the same among various points of view. Child workers, oriented towards a child, will find common elements of their work together. A Regional Training Program could make a unique contribution to this persistent, unresolved problem among professionals and trainers. With reality situations in sites within the regions, and with trainers and trainees working on actual problems, differences may be resolved that are fruitlessly pursued in discussions or lectures away from actual children.

Chapter V.
Research: Better Programs For Children

Purpose of Research. The Study Commission agreed that the purpose of research is to improve the quality and quantity of services to children and families in the continuing effort to accomplish the following goals:

The diagnosis and treatment of the emotionally and mentally sick child.

The prevention of illness whenever possible.

The achievement of optimal growth and capacity for all children.

More should be known about current efforts to help children—what is strong in programs, what is weak. We need to know how to improve existing programs and to know new ones that are needed. To begin work in this area requires looking at significant questions, having trained researchers, and funding research efforts.

Emphasis on Adequate Evaluation. Emphasis should be placed on program evaluation or assessment. Such evaluation efforts would be aimed at a better understanding of existing programs and should be an integral part of new programming. Evaluation designs should become a part of service, training, and education programs. Predetermined goals such as those designated at the beginning of this chapter should be a prerequisite for the evaluations.

Methods of Evaluation. Evaluation or assessment of current programs raises problems as to purposes, methods used, and the implications of evaluation results. Typically, child-helping agencies or services have found it difficult to utilize satisfactorily the usual research methodologies. Most research methodology has been devised to yield empirical evidence or proof of hypotheses. Many of these methods are not applicable to the study of the dynamic growth changes in a child's perceptions or feelings or relationships.

Interdisciplinary groups of clinicians, researchers, social scientists, statisticians recently have collaborated to develop new approaches to evaluation efforts. Some promising approaches include documented social histories related to the program which is evaluated. Another approach is the individual history of work with a child—that is, a clinical recording of the process of change

as the child shows his changing perceptions and feelings. Another method utilizes an action-research approach in that the professionals engage in a process of researching and studying their methods with the help of systems specialists, group dynamics experts, etc. Some researchers have helped professionals select small groups or sub-groups of children to study changes and to analyze variables among groups.

A current movement in evaluating the work of child-helping professions is the clarification of objectives for specific work with a child or group of children. In this sense, the professional enters into the definition of the area of concern and has a clearer picture of the concern, his relationship to it, and progress towards the goal. Although this approach narrows the problem area and reduces general and global goals to more specific ones, it offers the reward of more specific description of progress and goal attainment.

Child-helping agencies or staffs should enter into the formulation of evaluation designs for their programs rather than attempting to purchase or contract for a packaged "precut" evaluation. No known evaluation agency exists in or out of the State that can provide comprehensive immediate evaluation designs to fit specific agencies. Those agencies that have participated in evaluation and research efforts find that agency representatives need to participate in the process of devising an evaluation or research design so that the design fits the agency. Evaluation and research designs should be tailored by researchers and practitioners to ask significant questions and to seek significant answers.

Hopefully, the design will include mechanisms which provide for channeling results back into the practices of the agency and into the mainstream of other agency practices. In this way, dissemination of results becomes part of the design and helps provide ways of sharing findings or new knowledge.

Models or Examples to Study. Model programs and facilities within the State offer special services to children. Such programs may be considered prototypes which may be visited, observed, and analyzed as to successful components. When programs serve as models, they do not pretend to offer perfect solutions to problems. They may be described as exemplary demonstrations of programs in action which practitioners, planners, or researchers would find useful for study.

A recent statewide study conducted in one of the most populous states indicates that observations of demonstration programs is a key factor in promoting positive change in professional behavior and in institutional programs. This is a powerful argument for State leadership of child-serving agencies to assist in the development of exemplary programs. Such programs accomplish much more than quality services to those directly involved in the particular site—as important as that function is. By making its work observable and available to others, such a program demonstrates how problems can be solved and gives hope to professionals who want to improve other programs.

In developing the model idea for demonstration purposes for improvement of pro-

grams, it is important that State level leadership assert an active role in the process. No matter how exemplary a local or regional program, very seldom can its specific leaders act effectively as its sole dissemination agents. Program staffs that compete for funds, personnel, and professional standing may find it difficult to learn from each other and to truly recognize distinctive contributions of each other. It is helpful if another level of leadership—above local or regional rivalries—(a third party, so to speak) can assist local leadership in utilizing those findings from other programs that help them improve their own.

Steps to Facilitate Better Research. Today, child research in North Carolina is hindered by a shortage of trained personnel, lack of financial resources, lack of emphasis on conducting research and utilizing findings, and a lack of communication among individuals and agencies.

Current funding practices are detrimental to the development of research and to research utilization. Typical local, regional, or state funding for research—that is, actual funds set aside for this purpose—appears as a very minute part of total budget plans. Although descriptions of agency efforts generally include a reference to continued research and evaluation, agency budgets do not reflect funds sufficiently earmarked for such purposes.

The Study Commission has recommended that funding of research should be based on a percentage of service and training support at the rate of at least 10 per cent. Encouragement is also offered in the development of a cooperative arrangement to support private research groups. Arrangements should be made for research budget-sharing among State agencies and educational institutions.

The shortage of professionals working in mental health research in North Carolina necessitates increased support for training programs with an emphasis on research training. A survey conducted by the Task Force on Research in Child Mental Health revealed that there is a serious deficiency in North Carolina in the area of child mental health research. These deficiencies center primarily around a shortage of trained personnel, a lack of financial resources, a lack of emphasis on conducting and utilizing research findings, and a lack of coordination and communication among individuals and agencies concerned with mental health findings.

In local and State agencies, it is difficult to tell from an examination of staffing patterns exactly whose responsibility it is to formulate a research program for the agency. More than likely, each professional pursues his special interest if and as he chooses. Many times meaningful research is not undertaken due to pressing problems on operational levels and the administrative duties each professional must undertake. An agency may profit from employing a staff member especially knowledgeable in the research area, or it can encourage a staff member to become more sophisticated and trained in research. Another possibility is that an interested staff member might collect and distribute information from and to other staff members as to research interests and efforts. Staff members can have the stimulation of sharing interesting questions and of conducting investigations of personal interest, even in a small universe of concern.

To facilitate communication among interested individuals and agencies, a recommendation was made by the Study Commission to establish an information clearinghouse similar to the one now operating at the national level. This clearinghouse would maintain an up-to-date listing of research which is being done and by whom. In addition, it would list current funding sources for research such as foundations, State, and federal agencies.

Encouragement of staff exchanges for research purposes within the various State agencies and between State agencies and universities and research groups would maximize the productivity of the relatively few research personnel. Such collaboration could benefit all involved agencies and institutions.

Significant Questions Available to Researchers. There is no scarcity of topics available to child researchers. Many topics continue to interest child workers from one generation to the next. Some of these are the persistent questions of family relationships, child and adult relationships, healthful factors as to child development, etc. Other topics emerge from time to time based on social needs or crises, such as the effects of

TABLE 9. DATA FROM NORTH CAROLINA PROFESSIONALS DOING CHILD MENTAL HEALTH RESEARCH*

Discipline	Number of Current Studies	Source of Funds: Federal	State	Local	Foundation	Other	Total	Other Research Studies Done
Psychology	27	$215,326		$ 3,000	$10,000	$4,400	$232,726	43
Social work	4	ESEA Amt. Unknown	$ 8,142		Ford Fdn. EIP: Amt. Unknown		8,142 plus ?	2
Education	4	25,000					25,000	
Psychiatry	8	63,250	5,390	15,000			83,640	
Totals	43	$303,576+	$13,532	$18,000	$10,000+	$4,400	$349,508	45
Percentage of Research Support		87%	4%	5%	3%	1%		

* Reported by Task Force on Research

wars, pollution, mobility, poverty, etc.

We need research efforts to find out what occurs in child development between conception and age six, what kind of day care standards should be required, and what methods of early screening and evaluation will best detect physical and emotional difficulties. We need to know more about disadvantaged children and how traditional services and educational methods should be modified to help them. We need to know more about adolescents to help prevent the alienation that leads to drug abuse and juvenile delinquency. We need to develop more effective communication and counseling for this age group.

Since the years from conception to age six are so important for both physical and emotional development, a major focus should be on improving all aspects of service to these children. The various health professions, as well as the broad field of social service, should be made aware of the developmental needs of pregnant women, infants, and children. The increased use of allied health professionals, such as infant caretakers, requires that the training of these needed personnel be evaluated. Research efforts need to be directed toward program standards for day-care centers and regular evaluations be made mandatory for licensing. The quantity and quality of foster homes should be improved by setting of standards for both physical and emotional care. Methods of screening and assessment of preschool children should be sought. The Learning Institute of North Carolina has developed an assessment program for the demonstration kindergarten program which could serve as an example.

The special needs of children exposed to poverty, broken homes, lack of emotional and/or physical care, and other factors detrimental to positive development, should be assessed carefully. These special needs frequently require modification of the traditional services and educational methods. Thus, a mere enlargement or extension of traditional help may not only be useless, but it may aggravate particular situations.

Chapter VI.
A Governor's Advocacy Commission for North Carolina

The Major Recommendation Of The Study Commission. From the beginning of its work, it was the consensus of the Study Commission that the enlargement of existing institutions and agencies would not be sufficient to meet children's needs. All studies, testimonies, and position papers pointed to the need for a new mechanism by which the improvements suggested in the preceding chapters could be accomplished. In order to insure delivery of services to children, youth, and their families, the Study Commission recommends that:

> North Carolina should establish a Governor's Advocacy Commission on Children and Youth by legislative action. The Advocacy Commission would plan, facilitate, and coordinate services and would serve as an advocate in the interest of children, youth, and their families. It should take as its mandate the security and rights of all children and youth in North Carolina. The Commission would not be responsible for providing services directly, as this function would be incompatible with its role as advocate.

Some Functions To Be Performed. The Governor's Advocacy Commission would act as spokesman for individuals and groups of children, youth, and their families and maintain a continuing assessment of efforts to serve children's needs. It would work with existing State agencies to develop approaches to fill the gaps in child care and help agencies coordinate their efforts, develop joint programs, and avoid duplication of programs. It would review new programs affecting children, recommend ways for the Governor and General Assembly to improve child care and serve as the State structure for coordinating communication with federal advocacy systems. It should provide information to the public on issues affecting children, youth, and their families and provide assistance in the development and coordination of regional and local child advocacy systems within the State. In its structure it would include methods for evaluating its effectiveness.

The Study Commission recommends that the Advocacy Commission be responsible directly to the Governor and the General Assembly in fulfilling its work and through

them to the people of the State. During the deliberations of the Study Commission, Commission members discussed this question of responsibility with the heads of State agencies who indicated that they can be supportive of such a function. Each State agency head is deeply involved in programs of his agency. Whereas each agency head would like to establish liaison and cooperative methods, there is no mechanism now that brings them together for children's programs. It is natural that each agency would be hesitant to make suggestions to other agencies who have heavy demands on use of funds, personnel, and programs. Therefore, an Advocacy Commission responsible to the highest level of State Government would provide a needed mechanism for State agencies and State leadership for children's programs.

The Advocacy Commission will not replace any existing agency. It will not provide services directly to a child. Rather, it will advocate on behalf of children of the State. Although services and personnel are limited, the pressing need in the State seems to be for coordination of services and programs that do exist and for multi-agency planning in order to provide comprehensive services.

The composition of the Advocacy Commission is proposed in order to give representation to citizens and youth, legislators, and State agency heads. It is hoped that the Advocacy Commission would be representative of the adults and youth of the State as to geographical distribution, age, race, and sex. Primarily, it is hoped that the Commission would be composed of persons who could be wise child advocates, free to work for the best interests of children.

Recommended Composition of Commission and Its Staff. The Advocacy Commission should be composed of nineteen persons as follows:

Nine citizens, appointed by the Governor.

Two youth representatives, appointed for two-year staggered terms; one youth 16-21 years of age, and one youth below age 16.

Seven citizens, appointed for four-year staggered terms.

These citizens should include persons who have evidenced an interest in and a knowledge of the problems of children and youth, persons who work with them on a daily basis, and representatives of organizations concerned with the problems of children and parents.

Four members of the General Assembly, two from the Senate, appointed by the President; two from the House of Representatives, appointed by the Speaker; these four appointees to serve two-year terms.

Administrative heads (or designated representatives) of the Departments of Health, Mental Health, Social Services, Public Instruction, Juvenile Correction, and Local Affairs.

If agency representation on the Commission is increased, citizens representation should be increased by like number in order that opinions and talents of both citizens and professionals may be utilized.

The Advocacy Commission should be assisted in its work by a professional staff, consisting of an executive director and such associates and helpers as deemed necessary by the General Assembly to carry out the work of the Commission.

Some Priority Needs for Commission Action. The Advocacy Commission should consider itself an ombudsman for the children of North Carolina, taking their rights, needs, and grievances as its mandate, and exerting all effort—including legal power—to advocate the interests of children. The Advocacy Commission should have access to the State Attorney General and to other State offices as needed.

The Advocacy Commission should begin its work by taking inventory of all existing services for children and youth in the State, making use of the studies and recommendation of this Study Commission, other recent studies, and conducting further investigation where necessary. The Commission will then be able to set priorities and direct its attention to areas of greatest need.

The Advocacy Commission should give high priority to activities which will insure proper diagnosis, treatment, and care for children and youth who have emotional, mental, and physical handicaps. The Advocacy Commission must regard treatment services and preventive programs as complementary activities, each highly important in strengthening and improving life's quality for all children, youth, and their families.

The Advocacy Commission should initiate and encourage direct communication among children and families and agencies which serve them. Children often find it hard to be heard in their families; parents often find it hard to understand their children. It is all too easy for adults to believe they know the needs, desires, and best interests of children. In fact, they may be proceeding in a way directly contrary to the actual needs and feelings of children. The Commission should seek more effective means of using agencies to help family members talk and listen to each other.

Some people will feel that the Advocacy Commission might become just another structure of government to perpetuate itself, without a continuous assessment of itself. The Study Commission recommended that it be responsible and answerable to the Governor so that its visibility and accountability be open to the citizenry. By the nature of review by the Governor and the General Assembly every two years for funding, its work would be public business. The Study Commission also recommended that the Advocacy Commission be responsible for developing a self-study and evaluation design that would develop a description of objectives and would report the extent to which it was fulfilling these.

Critics of an Advocacy Commission may feel that such a State group would have either too much power or too little power to effect positive change. Proponents of the "too much power" group may fear authority vested in one State agency; that is, they may feel that a super-agency might be developed which would limit other agencies or prescribe their work. Proponents of the "too little power" group may feel that an Advocacy Commission without control of funds and planning may be just another agency by name without capability for effectiveness.

Political statesmen may recognize that the extent of power of an Advocacy Commission rests in the leadership and influence of its members and its director, and the extent to which the elected leadership of the people is responsive to the advocacy needs of the State. If the people of the State believe in the needs of children and direct their officials to do also, the Advocacy Commission can be developed strongly and beneficially.

Critics of child advocacy may feel that this movement was born out of concerns with emotionally disturbed children only. Others may feel that an Advocacy Commission in speaking for the cause of all children will again neglect the special needs of the emotionally disturbed child, and that treatment and intervention would be ignored. Hope-

fully, the Advocacy Commission will offer such persons a place to bring their concerns and will be capable of becoming their champions. It is also hoped that special groups will always have opportunities to lobby for special children. The Advocacy Commission will offer such groups assistance in the context of concern for all children. The Advocacy Commission's job will be to help with the difficulties, the wrongs, the forgotten ones, and to help develop ways to provide assistance.

Such an Advocacy Commission needs the support of many citizens of goodwill, citizens who are enthusiastic for these causes. It needs the support of the best trained child care professionals in the State. By identifying with its purpose citizens can find ways to build bridges of cooperative care for children.

If we ignore the need for such an Advocacy Commission, what alternatives have we? There is no existing agency with this mandate. No single agency can take on this job. No single person can. But citizens, through enlightened leadership, can perform an advocacy function through a Governor's Advocacy Commission.

A Governor's Advocacy Commission would lead the way for local and regional advocacy councils. Such councils would be developed by communities and regions to serve their needs and to relate their needs to other councils across the State.

Introduction of Local and Regional Advocacy and Some Functions. The Advocacy Commission should pave the way and help generate efforts for a unified approach to child care at the local or regional level. What occurs in the local community is most important since this is where services reach the individual child. In some communities, there are already informal and relatively unstructured programs of child advocacy at the local level, largely depending on the interest and skill of an individual or a project or civic organization. But a program of advocacy is needed to insure continuous recognized spokesmanship for children at the regional and local level. Local or regional advocacy councils should be created to perform such tasks as these.

Receive from individuals, agencies, civic groups, etc., suggestions for needed services for children, and determine those on which action can be facilitated.

Review proposals for new programs—national, State or local—which relate directly to the needs of children. Evaluate the resources for carrying out such programs.

Receive suggestions about services from individuals, agencies, civic groups, etc., and facilitate solutions to these. It could request reports from agencies regarding services when there is a question of privileged communication. It would participate in evaluation of agencies.

Review proposals for new funds and make recommendations regarding these. This review would include agency proposals for programs derived from tax sources.

Establish ties with health planning agencies to enhance communication and promote efforts for child programs within a broad approach to health planning.

Serve as a resource for groups, such as parents, concerned about unmet needs in developing programs or utilizing existing ones.

Maintain records on service functions in the region and make these available to those engaged in delivery of services to insure coordination.

Investigate and evaluate needs in order to help establish priorities in new programs.

Serve as a clearinghouse for agencies seeking to recruit new professionals. It would study manpower needs in child services and encourage universities, colleges, and technical schools to implement needed training programs.

Cooperate with local community groups in furthering their programs for children.

Cooperate with the Governor's Advocacy Commission and State agencies in insuring their commitments to children.

This chapter has presented the recommendations of the Study Commission for a Governor's Advocacy Commission on Children and Youth. Such a Commission would give leaders on the State level a basis for action on the main concerns of the Study Commission's report. These concerns include planning, program and services, training and research. The Advocacy Commission on the State level would assist with the development of local and regional advocacy councils which could be responsive to the direct needs of children in the communities where they live.

The Study Commission recognizes that much work lies ahead for those who attempt to improve conditions in the lives of children. In this Commission study, only the crucial issues have been identified and no simple solutions have been suggested. The Study Commission has attempted to point directions which might be taken in attempts to provide comprehensive programs for children, and to suggest a major mechanism or vehicle for leadership in such programs. The Study Commission is committed to confidence in the efforts of enlightened citizenry to advocate for children. It is hoped that this report has contributed to such enlightenment.

Appendix A

RECOMMENDATIONS OF THE STUDY COMMISSION

THE MAJOR RECOMMENDATION

1. North Carolina should establish a Governor's Advocacy Commission on Children and Youth by legislative action. The Advocacy Commission would plan, facilitate, and coordinate services and would serve as an advocate in the interest of children, youth, and their families. It should take as its mandate the security and rights of all children and youth in North Carolina. The Commission would not be responsible for providing services directly, as this function would be incompatible with its role as advocate.

It is recommended that the Governor's Advocacy Commission be composed of nineteen persons, including citizens, legislators, and administrators of child-serving agencies. It should encourage the formation of regional and local advocacy groups.

RECOMMENDATIONS ON PROGRAMS AND SERVICES

2. Greater emphasis should be placed on developing comprehensive services for children, utilizing all available agencies.

3. An information retrieval system to facilitate coordination of agency and professional efforts to aid children should be established. Access would be strictly on a professional need-to-know basis, and great care should be taken to guard the privacy of the involved individuals.

4. A central directory of available services should be established for use by professionals and private citizens.

5. More children's services should be developed by all agencies serving human needs.

6. Policies of agencies should provide that all services for children be performed as near the child's home as possible.

7. Since crisis work is done at the expense of preventive programs, departments concerned with health, education, and social services should coordinate development of pilot preventive projects for demonstration purposes.

8. Standards and guidelines should be established for "mothering care" in preschool and day care programs.

9. Day care programs for infants and preschool children should be improved and periodically evaluated. Licensing of programs should be mandatory.

10. Comprehensive programs for adolescent pregnancies, including counseling of both mother and father, should be developed.

11. More appropriate child care services should be made available to people who are unable to pay the full cost.

12. Preschool entry and evaluation programs should be established for five-year-olds.

13. North Carolina should continue the establishment of a statewide system of public kindergartens.

14. Within the public schools, emphasis should be placed on teaching children in the regular classroom. More school mental health programs, including a limited number of special classes within the context of a comprehensive program for emotionally disturbed children, should be developed.

15. Diagnostic and treatment services for children within existing mental health clinics should be expanded.

16. Services in Developmental Evaluation

Clinics and Child Health Supervisory Clinics should be expanded.

17. Separate child and adult facilities should be maintained in general and State hospitals, recognizing that occasionally it may be desirable to treat adolescents in facilities for adults.

18. The organizational structure of the juvenile courts and corrections should be unified. A system of mandatory reporting should be established for all juvenile courts.

19. Communities should be encouraged to establish specialized juvenile law enforcement units which are trained to work with children and parents.

20. Care should be taken to select juvenile court judges who demonstrate concern and competence with the specific problems of children.

21. Innovative residential programs for children should be encouraged, such as year-round camps, re-educational programs, therapeutic day care centers, night care programs, therapeutic nursery schools, therapeutic residential summer camps.

22. Residential treatment centers, in the continuum of child care services, should be given additional financial support and trained personnel.

23. Residential treatment centers should increase efforts to coordinate their programs with other community facilities and programs.

RECOMMENDATIONS ON MANPOWER AND TRAINING

24. The basic training of all mental health workers should include child development.

25. Quality in-service training programs for all State and local agencies with child-serving personnel should be established. This should include workers in mental health, social services, hospitals and other centers, teachers and administrators in public schools.

26. Regional inter-agency training programs should be established and should be financed by inter-agency funding. Programs should provide training for both new and experienced personnel. Teachers who conduct training programs should include practitioners who work well with children and who have the ability to teach. Training sites should utilize both traditional and innovative child service programs from which to teach.

All personnel working with children should be provided interdisciplinary training and information about many agencies. Training programs should emphasize child development lines: conception, infancy, preschool, school age, and adolescence. Training should emphasize direct work with children under qualified supervision rather than lectures about children.

27. A major training center should be established to provide training for work with children similar to the training provided by the Institute of Government for government officials.

28. Schools of medicine, nursing, and social work should place more emphasis in their programs on child development, including clinical work.

29. Departments of psychology should produce more practicing psychologists who can relate to children and parents and should develop master's programs in clinical psychology.

30. Child psychiatry training should comprise one-third to one-half of the residency training of all psychiatrists. Consideration should be given to shortening their traditional undergraduate and medical education.

31. Multidisciplinary programs on the graduate level should be expanded to train consultants for personnel working with children.

32. Undergraduates should be offered the opportunity to major in such disciplines as psychology and social work, and their training should equip them to provide services to children.

33. The curriculum of law schools should emphasize the legal rights of children and give more specific courses in juvenile law.

34. All agencies and institutions hiring untrained personnel should organize and accept responsibility for training programs to further the advancement of employees who show aptitude and interest.

35. New emphasis should be placed by agencies on the recruitment and training of employees, such as psychiatric, pediatric, or psychological aides, etc.

36. Educational institutions (for example, community colleges and technical schools) should be encouraged to develop innovative training programs for their personnel who show aptitude and interest.

37. Jobs for assistants, aides, and other personnel should be made available by opening opportunities for advancement.

38. As soon as possible, 50 per cent of the staff time of the State Department of Mental Health should be devoted to children.

39. The State Board of Education should be encouraged to seek legislative authority and funding to provide teacher training programs for disturbed children and to seek additional funds for the in-service training of all teachers.

40. Social service agencies should adopt a long-term goal of reducing the case loads of caseworkers to national standards.

RECOMMENDATIONS ON RESEARCH AND EVALUATION

41. Methods for evaluation of the Advocacy Commission function should be developed and implemented as soon as possible.

42. Greater emphasis must be placed on evaluation of programs and services for children.

43. Proposals should be evaluated before new programs are begun, and continuing evaluation should be built in. Model facilities and programs for special services to children, such as the Wright School and the Therapeutic Educational Program, should be studied to determine how and why they are successful.

44. Models showing the alternatives available for the education of exceptional children and the provision of special services for schools should be funded in each of the State educational districts. The Department of Public Instruction, with local school units and service agencies, should serve as contractor for services.

45. Greater research efforts should be directed toward developing preventive programs in child health and care.

46. At least 10 per cent of State funds for training and services should be spent for research and research utilization.

47. Programs should be developed to train more child-oriented researchers.

48. A research information retrieval system should be established to keep researchers up to date on projects and to provide information about private and governmental research grants.

Appendix B

TASK FORCE 1. CHILD ADVOCACY

Chairman: Mrs. Robert C. Blades, *Raleigh*

Honorary Chairman: Lt. Governor H. Patrick Taylor, Jr.

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Mrs. Robert L. Buckner, *Raleigh*
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Mrs. John K. Culbertson, *Raleigh*
Mrs. James Davis, *Durham*
Robert L. Denny, *Raleigh*
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Rev. Orion Hutchinson, *Brevard*
Mrs. Judith Kurzer, *Goldsboro*
Mrs. Stephen J. Maddock, *Raleigh*
Mrs. John McCain, *Wilson*
Senator Hector McGeachy, *Fayetteville*
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Dr. Richard S. Ray, *Durham*
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Fred B. Thompson, *Raleigh*
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Mrs. Carlton G. Watkins, *Charlotte*
Thomas P. Inman, *Raleigh* (Advisory Member)

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Mrs. Lester Beall, *High Point*
Mrs. George W. Brumley, *Durham*
Ronald G. Carroll, *Durham*
Mrs. Joseph C. Farmer, Jr., *Durham*
Dr. W. Scott Gehman, *Durham*
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Dr. James L. Paul, *Raleigh*
Dr. Richard S. Ray, *Durham*
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TASK FORCE 3. PRIVATE PRACTICE

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Vice Chairman: Will L. London, M.D., *Durham*

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Mrs. Milton A. Barber, *Durham*
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Miss Virginia Hebbert, *Chapel Hill*
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Ronald Knopf, *Wilmington*
Dr. Arnold D. Krugman, *Durham*
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TASK FORCE 5. HEALTH PROFESSIONS

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Vice Chairman: Dr. Robert E. Neely, *Raleigh*

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Mrs. Betty Dorman, *Chapel Hill*
Charles Dunn, *Raleigh*
Everett Ellinwood, M.D., *Durham*
Miss Patricia Gendrea, *Raleigh*
Miss Laura Harbison, *Raleigh*
Mrs. A. E. Harer, *Raleigh*
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Senator John Henley, *Fayetteville*
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Richard Kelly, M.D., *Fayetteville*
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John Parks, M.D., *Charlotte*
William A. Robie, M.D., *Raleigh*
William Seifert, *Raleigh*
Earl Seigle, M.D., *Chapel Hill*
William E. Smith, M.D., *Raleigh*
Mrs. J. Elvey Thomas, *Raleigh*
Fred H. Wagoner, *Raleigh*
Miss Katherine Wilson, *Raleigh*
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TASK FORCE 6. TRAINING OF PROFESSIONAL PERSONNEL

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Mrs. Jordan H. Parker, *Raleigh*
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Mrs. Ruth Shaw, *Raleigh*
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Dr. Harold Corter, *Raleigh*
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Lonnie Gilliam, *Asheville*
Dr. Joseph Himes, *Greensboro*
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Miss Beatrice Coe, *Durham*
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Cesar Guajardo, M.D., *Butner*
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Jack Hoyle, *Winston-Salem*
Dr. Octavia B. Knight, *Durham*
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Mrs. Anne Parrish, *Durham*
Representative Wade H. Penny, Jr., *Durham*
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Representative Kenneth Royall, Jr., *Durham*
Rev. B. Daniel Sapp, *Raleigh*
Mrs. June Stallings, *Durham*
Miss Mary C. Sumner, *Butner*
Mrs. Nello L. Teer, *Durham*
Mrs. Carolyn I. Thornton, *Durham*
Mrs. W. A. Watkins, *Raleigh*
Richard S. Yell, *Durham*

TASK FORCE 11. JOINT COMMISSION REPORT

Chairman: Eugene Hargrove, M.D., *Raleigh*

Vice Chairman: Harold Benson, *Raleigh*

Miss Kathryn Barclay, *Durham*
James T. Burch, *Raleigh*
Dr. Robert Byrd, *Pinehurst*
Mrs. John A. Cates, *Raleigh*
Mrs. Dorothy Ferrell, *Raleigh*
Miss Georgia Hughes, *Chapel Hill*
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Dr. Dorothy Williams, *Raleigh*
Dr. Ann Wolfe, *Raleigh*
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Vice Chairman: Mrs. Thomas D. Bunn, *Raleigh*

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Dr. Wayne Henderson, *Raleigh*
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Rev. Thomas L. Law, *Raleigh*
John H. Lucas, *Durham*
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William Perry, *Raleigh*
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Mrs. Charles Nesbitt, *Greensboro*
Mrs. Robert V. Sisk, *Charlotte*
Mrs. L. H. Staples, *Asheville*
Mrs. William H. Williamson, *Charlotte*

Appendix C

POSITION PAPERS

National Position Papers on the Joint Commission on Mental Health of Children
Presented By: American Psychiatric Association
State Mental Health Authorities
American Association of Psychiatric Services for Children
American Academy of Child Psychiatry

Problems Of, and Programs For, the Emotionally Disturbed Child in North Carolina
Presented By: Medical Society of the State of North Carolina
William N. Hilliard, Executive Director

Position Paper of the North Carolina Association of Social Workers in Mental Health
Presented By: North Carolina Association of Social Workers in Mental Health
Claudeline Lewis, Chairman, Position Paper Committee

Position Paper for the Study Commission on Emotionally Disturbed Children
Presented By: North Carolina State Board of Health

Position Paper of the North Carolina Council of Child Psychiatry
Presented By: North Carolina Council of Child Psychiatry
David Freeman, M.D., President

Position Paper on Services for Emotionally Disturbed Children
Presented By: North Carolina Department of Mental Health

Position Paper for the Study Commission on Emotionally Disturbed Children
Presented By: North Carolina Department of Social Services
Dr. Dorothy Park Griffin, Chief, Psychological Services Section

Position Paper for the Study Commission on Emotionally Disturbed Children
Presented By: North Carolina Psychological Association
Dr. Dorothy Park Griffin, Chairman, Mental Health Committee

Position Paper on the Public School Program for the Emotionally Disturbed
Presented By: Developmental Evaluation Clinic
Western Carolina University
Dr. William R. Center, Chairman

Report to the Study Commission for Emotionally Disturbed Children
Presented By: North Carolina Department of Public Instruction
Division of Vocational Rehabilitation

Position Paper on the Education of Emotionally Disturbed Children
Presented By: North Carolina Department of Public Instruction
Division of Special Education
Ronald Ausdenmoore

Position Paper for the Study Commission on Emotionally Disturbed Children
Presented By: North Carolina Society for Autistic Children
Frank Warren, President

A Report on Child Health in Eastern North Carolina
Presented By: Task Force on Child Health in Eastern North Carolina
William DeMaria, M.D., Chairman

Appendix D

RECOGNITION OF GROUPS CONTRIBUTING TO STUDY

The Study Commission on North Carolina's Emotionally Disturbed Children wishes to recognize and express appreciation to the State agencies and other cooperating groups whose efforts made the findings of the Commission possible. Among those contributing to the work of the Commission are:

State Agency Heads and Staff: Director, State Board of Health; Superintendent, State Department of Public Instruction; Commissioner, Board of Juvenile Correction; Commissioner, State Department of Social Services; Commissioner, State Department of Mental Health; Executive Director, North Carolina Council on Mental Retardation; Director, Learning Institute of North Carolina; Attorney General of North Carolina.

Other Cooperating Groups: Junior Leagues of North Carolina; North Carolina Medical Society; State Government Reorganization Study Commission; North Carolina Mental Health Association; North Carolina Congress of Parents and Teachers; North Carolina Health Council; North Carolina Mental Health Council; North Carolina Legislative Study Commission on Use of Illegal and Harmful Drugs; Mary Reynolds Babcock Foundation; other local and State groups.

Credits for Photography: Hugh Rogers, pages 3, 19; Carl Purcell, National Education Association, pages 5, 18, 23, 66 (upper); Joe DiDio, National Education Association, pages 24 (lower), 25, 26, 38; Jonathan King, Educational Facilities Laboratory, page 48; Junius Grimes, pages 45, 64 (lower right); George S. Zimbel, Education Facilities Laboratory, pages 36, 62, 64 (upper right, lower left), inside back cover; Warren Uzzle, THE RALEIGH TIMES, page 57; James E. Neinast, pages 11, 15 (lower), 42; Junior Leagues of North Carolina, pages 40, 61 (right); Narco Scientific Industries, page 46; LAUREL, Millbrook High School, Wake County, pages 24 (upper), 41, 49 (upper); Robert W. Hart, THE BIBLICAL RECORDER, page 14; Durham Education Improvement Program, pages 39, 47; Tony Rumple, courtesy Durham Morning Herald, page 53, and the Cooperative School, page 44; North Carolina Department of Mental Health, page 59; Learning Institute of North Carolina, page 49 (lower).

Courtesy of:

Art Kane, LOOK MAGAZINE 1971, page 15 (upper); Roy Hardee, pages 22, 34, 43, 61 (left), 66 (lower).

Appendix E

NORTH CAROLINA
GENERAL ASSEMBLY
1969 SESSION
RATIFIED RESOLUTION

RESOLUTION 75
SENATE JOINT RESOLUTION 629

A JOINT RESOLUTION CREATING A COMMISSION TO STUDY AND RECOMMEND MEASURES FOR NORTH CAROLINA'S EMOTIONALLY DISTURBED CHILDREN.

WHEREAS, there are an estimated 193,000 emotionally disturbed children in North Carolina; and

WHEREAS, these children are not retarded, and are capable of becoming productive adults of the future — if they receive help; and

WHEREAS, unhelped, these same children could grow up to be the problem adults of the future — alcoholics, criminals, mental patients and welfare dependents at great cost to the State; and

WHEREAS, forty-five percent (45%) of our first graders never finish high school — even in this day of compulsory education; and

WHEREAS, our state school system's provisions for the emotional needs of children are most inadequate; and

WHEREAS, there are only 110 beds in North Carolina's mental hospital for the thousands of children in need; now, therefore, be it resolved by the Senate, the House of Representatives concurring:

Section 1. There is hereby created a Commission to be designated as the Study Commission on North Carolina's members. Three shall be appointed by the Lieutenant Governor and three shall be appointed by the Speaker of the House of Representatives.

Section 2. The Commission shall hold its first meeting at such time and place as may be designated by the Chairman.

Section 3. It shall be the duty of the said Commission to study in-depth the situation of the emotionally disturbed child in North Carolina and the mental health needs of all children in the State. This study should cover measures for prevention, educational intervention and treatment.

Section 4. Members of this Commission shall be paid a per diem allowance and travel expenses as provided generally by law for members of State boards and commissions.

Section 5. After completing its investigation and study this Commission shall file a report with the Governor and the General Assembly by the convening of the 1971 Session of the General Assembly.

Section 6. This Resolution shall become effective upon its adoption.

In the General Assembly read three times and ratified, this the 9th day of June, 1969.

s/ H. P. Taylor, Jr.
President of the Senate.

s/ Earl W. Vaughn
Speaker of the House of Representatives.

Appendix F

GENERAL ASSEMBLY OF NORTH CAROLINA
1971 SESSION
HOUSE BILL 203
SENATE BILL 134

Short Title: Youth Advocacy Commission
Sponsors: Representatives Chase and Raynor
Senators Henley and O'N. Jones
Referred to: Health

February 12
A BILL TO BE ENTITLED
AN ACT TO AMEND CHAPTER 110 OF THE GENERAL STATUTES TO ESTABLISH THE GOVERNOR'S ADVOCACY COMMISSION ON CHILDREN AND YOUTH.

The General Assembly of North Carolina do enact:

Section 1. Chapter 110 of the General Statutes is hereby amended by inserting immediately after Article 5 a new Article to be numbered Article 6 and to read as follows:

"Article 6.

Governor's Advocacy Commission on Children and Youth.

110-65. *Short Title.* — This Article may be cited as the Governor's Advocacy Commission on Children and Youth Act.

110-66. *Legislative purpose and intent.* — The General Assembly finds there is need for better planning and more effective coordination among public and private agencies serving children and youth in North Carolina in order to improve inadequate programs, to avoid duplication of effort and waste of resources, to provide for unmet needs, and to improve delivery of services. By this act creating a unit of State government to be an advocate for the broad needs and interests of children, the General Assembly intends to provide an answer to these problems so that public and private agencies may be more responsive to the needs of children and youth in this State.

110-67. *Advocacy commission established.* — (a) The Governor's Advocacy Commission on Children and Youth (hereinafter called the "Commission") is hereby established in the North Carolina Department of Administration to serve as an advocate of the interests of the children and youth within the State and local governments and with private agencies serving children and youth.

(b) The Commission shall be advisory to all agencies of State and local government that provide services to children and youth or their families.

(c) The Commission shall not operate any programs providing direct services to children or youth or their families, since the provision of services is incompatible with its primary role as child advocate.

110-68. *Membership of Commission.* — The Commission shall consist of the following 19 members:

two members of the Senate, appointed by the President of the Senate;

two members of the House of Representatives, appointed by the Speaker of the House of Representatives;
the State Health Director;
the Commissioner of Social Services;
the Commissioner of Mental Health;
the State Superintendent of Public Instruction;
the Commissioner of Juvenile Correction;
the Director of Local Affairs;
seven other adult citizens appointed by the Governor;
two youth members appointed by the Governor.

Any ex officio member may designate another person to represent him on the Commission, and that designee shall have all the powers of other Commission members.

110-69. *Terms and eligibility.* — (a) The members of the General Assembly appointed to the Commission shall serve a term of four years, except that of the initial appointments, two shall be for a term of one year, two shall be for a term of two years, two shall be for a term of three years, and one shall be for a term of four years, in order to provide for staggered terms. In selecting the seven adult citizen members of the Commission, the Governor shall include persons who have an interest in and knowledge of children and youth, persons who work with children, and representatives of organizations concerned with problems of children and youth. In selecting the youth members, the Governor shall appoint one who is between the ages of 16 and 21 years of age and one who is less than 16 years of age at the time of their appointments. The youth members shall serve a term of two years, except that one of the initial appointments shall be for a term of one year and one shall be for a term of two years, in order to provide staggered terms.

(b) Vacancies. Any vacancy occurring in any appointive position prior to the regular expiration of the term shall be filled by appointment of the Governor or the presiding officer authorized to make the initial appointment for the remainder of the unexpired term.

110-70. *Organization of the Commission.* — (a) The Commission shall annually elect its own chairman, who shall be one of the members appointed from the General Assembly or by the Governor. No member of the Commission shall serve as chairman for more than four consecutive terms of one year. The Commission may elect such other officers from its membership as it deems necessary. The members of the Commission who are not officers or employees of the State shall receive for their services the per diem and allowances prescribed in G.S. 138-5.

(b) Meetings. The Commission shall meet quarterly or upon call of the chairman. Ten members of the Commission shall constitute a quorum for the purpose of conducting its business.

110-71. *Powers and duties of Commission.* — The Commission shall have the following powers and duties:

(1) It shall appoint the administrator of the Commission with the approval of the Governor. The administrator shall be a qualified professional person with substantial knowledge of and experience in State government and related to the problems of children and youth.

(2) It shall act as an advocate for children and youth within State and local governments, and with private agencies serving children and

youth, and it shall provide assistance in the development and coordination of child advocacy systems at the regional and local levels within the State.

(3) It shall conduct a continuing review of existing programs of State government for children and youth and their families by gathering data, studying existing services, evaluating the delivery of services, and in other ways that it deems appropriate.

(4) After appropriate review and study, it shall identify needs of children and youth and their families that are not being met by existing programs or that are being met inadequately, and when such gaps or inadequacies in services are identified, it shall recommend such new programs or improvements in existing services as it finds are needed, planning cooperatively with the appropriate State, local or private agencies.

(5) It shall work with State and local agencies, both public and private, to help them to coordinate existing services more effectively, to engage in joint endeavors, to avoid duplication of services, and in other ways to make more effective use of available resources.

(6) It shall review any new programs affecting children and youth that are proposed by any State agency in order to make to that agency recommendations intended to avoid duplication of services, to promote better planning, to indicate ways in which the proposed program could be improved, or otherwise to make more effective use of available resources.

(7) It shall make reports and recommendations to the Governor and the General Assembly from time to time when it accumulates data which could aid in State planning or whenever the Commission finds that it would be helpful to make a report.

(8) It shall provide information to State and local agencies serving children and youth and their families, both public and private, as it finds to be appropriate.

110-72. *Powers and duties of the administrator.* — The administrator of the Commission shall have the following powers and duties:

(1) He shall administer and implement the recommendations and findings of the Commission, working cooperatively with the appropriate agencies, both public and private.

(2) He shall conduct such studies as are directed by the Commission with respect to the needs of children and youth, the programs and services of State and local agencies, both public and private, and he shall furnish such information, data, or reports as may be needed for the Commission to be an effective child advocate.

(3) He may appoint such subordinate personnel as may be approved by the Director of Administration.

(4) He shall encourage the development of child advocacy systems on the regional and local levels in the State by working cooperatively with local leadership within the State."

Section 2. This act shall become effective on July 1, 1971.

Appendix G

GENERAL ASSEMBLY OF NORTH CAROLINA
1971 SESSION
HOUSE BILL 204
SENATE BILL 135

Short Title: Youth Commission: Appropriations.
Sponsors: Representatives Chase and Raynor
Senators Henley and O'N. Jones
Referred to: Appropriations

February 12

A BILL TO BE ENTITLED
AN ACT TO APPROPRIATE SIXTY THOUSAND DOLLARS ($60,000.00) FOR THE CONDUCT OF THE GOVERNOR'S ADVOCACY COMMISSION ON CHILDREN AND YOUTH.

The General Assembly of North Carolina do enact:

Section 1. There is hereby appropriated from the General Fund to the Department of Administration for the conduct of the Governor's Advocacy Commission on Children and Youth the sum of sixty thousand dollars ($60,000.00) for the 1971-73 biennium.

Section 2. This act shall become effective on July 1, 1971.

Appendix H.

NORTH CAROLINA CHILD POPULATION BY COUNTIES AND CLINIC ADMISSIONS, 1968-69

WESTERN REGION	68-69 Total Population	Under 18	Percentage Under 18	Total County Admissions to Clinics	Under 18	Percentage Under 18
Cherokee	11,264	5,283	30.6	34	7	20.6
Clay	5,554	1,616	29.1	27	13	48.2
Graham	6,732	2,249	33.5	5	1	20.0
Haywood	42,548	13,147	30.9	104	39	37.5
Jackson	20,377	6,011	29.6	89	9	10.1
Macon	15,023	4,327	28.8	19	3	15.7
Swain	8,454	3,458	40.9	11	3	27.3
Yancey	13,724	4,049	29.5	18	1	5.5
Buncombe	147,063	46,766	31.9	462	137	29.6
Madison	15,497	3,440	22.2	21	3	14.3
Mitchell	13,218	4,679	35.4	18	7	38.9
Alleghany	8,200	2,312	28.2	41	7	17.1
Ashe	20,498	6,887	33.5	60	15	25.0
Avery	12,658	4,051	31.9	15	0	0.0
Watauga	23,103	6,769	29.3	115	26	22.6
Wilkes	49,855	18,147	36.4	121	21	17.3
Henderson	41,930	12,914	30.8	212	42	19.8
Transylvania	19,620	7,103	36.2	72	14	19.4
Alexander	18,241	6,111	33.5	37	3	8.1
Burke	62,423	19,414	31.1	216	7	32.4
Caldwell	57,753	21,080	36.6	169	15	8.8
McDowell	30,944	12,656	41.0	87	10	11.5
Polk	11,249	3,746	33.3	9	0	0.0
Rutherford	49,059	14,816	30.2	371	65	17.5
Cleveland	70,490	25,870	36.8	360	92	23.8
Gaston	144,243	48,899	33.9	441	143	32.4
Lincoln	33,279	11,415	34.6	32	2	6.5
Catawba	89,374	29,940	33.5	263	24	9.1
Mecklenburg	344,951	124,527	36.1	1,007	214	21.2
Davie	19,122	6,368	33.3	15	3	20.0
Iredell	71,679	25,876	36.1	392	99	25.2
Rowan	94,154	28,529	30.3	556	266	47.8
Subtotal	1,572,279	532,455	33.9	5,399	1,291	23.9

NORTH CENTRAL REGION	68-69 Total Population	Under 18	Percentage Under 18	Total County Admissions to Clinics	Under 18	Percentage Under 18
Surry	53,132	17,427	33.0	10	3	30.0
Yadkin	23,971	7,839	30.0	5	0	0.0
Forsyth	213,540	75,380	28.0	790	196	24.8
Stokes	24,393	8,586	33.0	9	1	11.1
Rockingham	73,599	24,729	33.0	38	10	26.3
Guilford	278,340	96,862	34.0	1,022	288	28.1
Alamance	94,374	32,842	34.0	671	177	26.3
Caswell	23,360	8,165	34.0	12	5	41.7
Chatham	29,764	9,405	31.0	49	10	20.4
Orange	56,465	16,431	29.0	458	124	27.5
Person	27,696	10,857	39.0	113	25	22.1
Durham	129,556	40,551	31.0	677	244	36.0
Franklin	28,012	11,261	40.0	109	29	26.6
Granville	35,870	12,590	35.0	37	26	70.2
Vance	34,443	13,443	38.0	179	57	31.8
Warren	16,952	7,459	44.0	33	4	12.1
Subtotal	1,143,467	393,827	34.4	4,212	1,199	28.5

SOUTH CENTRAL REGION	68-69 Total Population	Population Under 18	Percentage Under 18	Total Clinic Admissions by County	Under 18	Percentage Under 18
Cabarrus	76,309	24,495	32.1	412	146	35.4
Union	51,541	18,091	35.1	17	8	47.0
Davidson	94,963	34,377	36.2	263	35	13.3
Hoke	17,583	8,088	45.9	74	19	25.6
Montgomery	19,560	6,983	35.7	84	10	11.9
Moore	40,210	14,998	37.2	200	61	30.5
Richmond	39,781	14,719	37.0	199	67	33.6
Bladen	27,701	11,385	42.0	66	20	30.3
Columbus	48,857	19,836	40.6	232	90	38.7
Robeson	91,936	40,544	44.1	518	215	41.5
Scotland	26,991	10,985	40.6	169	53	31.3
Cumberland	226,942	88,734	39.1	1,174	529	45.1
Sampson	48,506	18,432	38.0	33	6	18.1
Harnett	42,548	17,457	41.1	259	80	30.9
Lee	30,004	11,462	38.2	278	154	55.4
Johnston	63,054	21,438	35.0	250	36	14.4
Wake	219,104	74,495	34.0	1,740	434	24.9
Anson	24,222	9,519	39.3	21	10	47.6
Stanly	43,404	14,063	32.4	19	5	26.3
Randolph	76,513	25,096	32.8	317	94	29.6
Subtotals	1,309,729	485,197	37.0	6,325	2,072	32.8

EASTERN REGION	68-69 Total Population	Population Under 18	Percentage Under 18	Total Clinic Admissions by County	Under 18	Percentage Under 18
Brunswick	22,607	8,794	38.8	9	3	33.3
New Hanover	81,496	28,524	34.8	610	164	26.8
Pender	17,950	6,839	38.6	20	3	15.0
Duplin	37,758	14,650	38.7	34	9	26.4
Onslow	100,181	35,665	35.5	247	96	38.8
Wayne	91,691	37,685	41.1	479	187	39.0
Greene	15,824	7,184	45.3	35	11	31.4
Wilson	61,029	21,787	35.6	272	79	29.0
Edgecombe	54,636	23,166	42.4	194	43	22.1
Nash	64,004	25,346	39.6	229	57	24.8
Halifax	58,366	24,572	42.1	183	36	19.6
Carteret	32,163	11,257	35.0	101	35	34.6
Craven	67,683	26,870	39.4	296	132	44.5
Jones	10,205	4,725	46.3	28	8	28.5
Pamlico	9,466	3,635	38.3	46	26	56.5
Lenoir	56,582	22,746	40.2	307	111	36.1
Pitt	78,630	29,486	37.4	347	85	24.5
Bertie	23,527	8,870	30.0	87	25	28.7
Gates	9,377	3,432	36.6	36	16	44.4
Hertford	23,026	9,487	41.1	147	65	44.2
Northampton	24,922	10,567	42.4	83	29	34.9
Beaufort	36,893	13,946	37.8	245	84	34.2
Hyde	5,535	1,799	32.6	12	2	18.3
Martin	25,516	11,329	44.3	79	21	26.5
Tyrrell	4,049	1,632	40.3	18	9	50.0
Washington	14,254	5,883	41.2	49	20	40.8
Camden	5,469	2,198	40.2	2	0	0.0
Chowan	12,052	4,375	36.3	3	0	0.0
Currituck	6,713	2,430	34.7	0	0	0.0
Dare	6,490	1,934	29.8	5	0	0.0
Pasquotank	27,529	10,268	37.3	12	2	18.3
Perquimans	8,727	3,744	43.0	2	1	50.0
Subtotal	1,094,350	424,825	38.8	4,217	1,359	32.2
STATE TOTAL	5,119,825	1,836,304	35.9	20,153	5,921	29.4

Appendix I

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In the Name of Progress

Golden ripe wheat waving in the sun
Blending with black soil, crushed by the plow
Gone, in the name of subsidization
and a child hungers.

Dancing lights waver on a silver ceiling
Glasses clink and bodies sway crazily
Mindless, in the name of laughter
and a child cries.

Howling wind on a wintry night
Gusts of rain, lights, a screech, a scream
Death, in the name of speed
and a child is sad.

Feather footsteps fall on green cheese
A billion dollars in a giant step of litter
Headlines, in the name of progress
and still a child suffers.

Hushed, still, he waits
for people
to unlock their minds
and remember.

B. J. T.
A North Carolina Student
Age 15

Appendix I

ORIGINAL POETRY BY [illegible]

Jack Name of Hoover

Cinder-man is at work in the sun
Blending with black and crushed by the iron
Gone, in the cause of modernization
and a child hungers.

Dancing feels secure on a silver cloud
Glasses clink and laughter rings crazy
Mindless, in the cause of laughter
and a child cries.

Marching tired on a starless night
Glory of war, lights a fresh, a scream
Death, in the name of speed
and a child is sad.

Earth, forever, clad in green [illegible]
A million years in a giant step of time
Iron flows, in the cause of progress
and still a child suffers.

[illegible] will, [illegible]
[illegible] for people [illegible]
to unlock [illegible] mind
and remember [illegible]

B. J. T.